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MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003—Continued

Ms. PELOSI. Mr. Speaker, the Democratic plan does just that. This Republican bill, I repeat, is not guaranteed. It is not affordable. It is not a defined prescription drug benefit under Medicare that our seniors want and deserve. The Republican plan is a plan to end Medicare. I urge my colleagues to reject this raw deal for America's seniors and vote no on the Republican bill and yes on the very excellent Democratic proposal.

Mr. TAUZIN. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, when we test the arguments made on the floor of the House on a major piece of legislation such as this, it is important to test the credibility of those arguments. The best way to test that credibility is to first of all tell Members a fairy tale.

Once upon a time Bill Clinton proposed Medicare prescription drug coverage for America. Once upon a time my Democratic friends, the gentleman from California (Mr. STARK), the gentleman from Michigan (Mr. DINGELL), the gentleman from California (Mr. WAXMAN), the gentleman from New York (Mr. RANGEL), the gentleman from Ohio (Mr. BROWN), and many others introduced a bill, H.R. 1495.

Once upon a time Democrats recommended a bill with a $200 deductible, 80 percent cost sharing by the government up to $1,700 of drug expenses, a doughnut hole, and then $3,000 out-of-pocket catastrophic coverage with no defined premium. And guess what, once upon a time their bill provided that the benefits would be provided through a PBM. Members might ask how would the PBM be selected: By competitive bidding.

Members might further ask how would the contracts be awarded under this privatization of Medicare, and the answer in a fairy tale world would be shared risk capitation of performance. But the truth is this is not a fairy tale. It happens to be the truth. That was the Democratic proposal on Medicare prescription drugs, but tonight Democrats have come to the floor one after the other and criticized this plan because it contained many of those same features. Different, however, in some respects because this plan provides better coverage for seniors on the bottom. In fact, while some of my friends came to the floor and called this a sad day and said how sorry they were for the citizens of California, this bill we proposed would put 1.4 million California senior citizens in plans that would cost them no premiums, no deductibles, free entry for drugs in California for 1.4 million senior citizens, half a million in Indiana, half a million in Ohio, half a million in Pennsylvania, almost a million in Texas, and so on and so forth, free drug coverage under this plan, and yet the fantasy plan offered by the Clinton administration just a few years ago containing many of the same elements is somehow forgotten. It is somehow put away in a closet. It is somehow not to be remembered, and this plan is to be attacked. When we test credibility of arguments on the floor of the House, test them against the reality of the plan offered by the Democrats and the reality of the plan offered today.

I want to thank the gentleman from Michigan (Mr. DINGELL) for the courtesies and the respect and the statesmanship he has always shown me in debates in committee and on the floor of House. The gentleman is a dear friend. I wish I could say that about all Members all the time. But let me say something, I am offended that anyone would come to this floor and accuse anyone in this House of wanting to get old people. Do Members think for a second they love their moms and dads any more than we love ours?

I ask the gentleman from California (Mr. STARK), do you really believe that? God bless them. That is the sort of unstatesmanship that should never enter the halls of this House.

There is nobody in this House that loves their mother more than I love my mother. I challenge Members on that. She is a three-time cancer survivor, she is 84 years old, and she won first place at the Senior Olympics this year in shotput, and if you give her trouble, I will sic her on you.

There are Members who have come to the floor and said seniors cannot understand choice. Let me tell Members something, I grew up in a poverty family. My mom and dad never earned above poverty. They made hard choices all their life for us. They sent three out of their four children to college. They fed and clothed us and gave us a great education and a chance for me to come to Congress. I love that woman and I loved my dad as long as I had him. How dare anyone suggest otherwise. We love our parents and grandparents the same.

We differ on how to structure this program today. Apparently we did not a few years ago, but we do now. That is a legitimate debate and that is worthy of this House, but to suggest that any of us care less about old people, to suggest that any of us love those citizens who gave so much and made those hard choices for us any less than we do is a shame. My parents made hard choices. My mother knows how to make hard choices. If we give her choices, she will make the right ones, just like she did all her life. I trust her and I trust seniors in America. We are going to give them drug coverage in Medicare and we are going to give them other choices, too, if they want to make those choices. And if Members do not want to help us do it today, I suggest in a month from now when the conference

committee report is back after a compromise with the Senate, you might want to join us then.

Mr. ISTOOK. Mr. Speaker, this bill will hasten the day when Medicare will go bankrupt, and it also threatens to unravel our children's future.

Medicare is already on shaky financial legs, and this will add enormous extra expenses that will make it worse. Do we expect our children to pay a lifetime of higher taxes, and still find there's nothing left for them when they retire? That is what we face.

I would like to add prescription drug benefits, but it's wrong to promise something we cannot pay for.

I want to preserve what's good about Medicare, not destroy it by making extravagant promises for political gain.

The enormous extra spending under this bill will be far more than projected. Because today's Medicare is a huge price control system, many doctors already refuse to see Medicare patients. In just a few years this will make it worse, including price controls that will destroy the incentives for companies to create new medicines.

What should we be doing?

Since 76 percent of seniors already have drug coverage, we could focus on helping those who don't. But this bill undoes the coverage for those 76 percent, and puts them in a confusing new medical experiment.

We should be stabilizing Medicare, so it can keep the promises already made, not making new promises that we don't have the money to keep.

We should address the reasons why drug prices and healthcare costs are so high. By banning re-imported drugs, we're forcing Americans to subsidize far-lower drug prices in other countries. We should change our policies so Americans only pay the lower world price, not a higher price.

We should end the 130,000 pages of federal regulations that have driven the costs of medicine and healthcare through the roof. On average, for every hour they spend with a patient, doctors and nurses spend another half-hour doing government paperwork.

We should stress personal responsibility in healthcare, just as we did in welfare reform, so government resources are focused on those who cannot care for themselves, not on those who can.

Bit-by-bit, Congress is undoing the principles of welfare reform, and undercutting basic American principles in the process. Both political parties are making extravagant promises today, trying to outbid each other to win votes. Unfortunately, they are bidding with taxpayers' own money, and our children's hopes will be crushed by the bills they will inherit.

Mr. UDALL of New Mexico. Mr. Speaker, for far too long, as I traveled around the state of New Mexico, seniors have told me their heartbreaking stories of being forced to choose between purchasing their medicine and purchasing groceries as a result of the exploding costs of prescription drugs. Today we have an excellent opportunity to address this tragic situation by providing a prescription drug benefit for Medicare beneficiaries and put an end to the outrageous dilemma facing our seniors throughout the country. In addition, we have an historic opportunity to modernize the incredibly important Medicare program, including updating formulas for our health care providers in rural areas—an issue that is of particular importance to my constituents and me.

Thankfully, H.R. 1 does address the latter concern, but unfortunately falls far short on the critically important issue of prescription drug coverage. The prescription drug benefit provided under H.R. 1 would be the first step toward privatizing one of the most successful government programs in history, leaves seniors at the mercy of insurance companies, forces seniors into HMOs, has an incredible gap in coverage, and does nothing to control the exploding costs of prescription drugs. As such, I am forced to vote against H.R. 1.

Under this bill, seniors and disabled Medicare beneficiaries can obtain their prescription drug coverage only from HMOs and private insurance companies. Given the history of HMOs and other private health plans in rural areas, I have serious concerns about this approach. In fact, in 1997 in the state of New Mexico, HMOs dropped approximately 18,000 individuals because of rising costs. These individuals were left with nowhere to turn.

H.R. 1 would put beneficiaries at a similar risk by relying on untested private drug-only plans, which can decide whether or not to serve rural areas, and they can decide to leave every 12 months. Further contributing to the risk of this provision is the fact that there is no fallback option to allow traditional Medicare to provide prescription drug coverage if private plans decline to provide coverage in rural areas. Because much of my district is rural, this legislation would put the seniors in my district at particular risk. I cannot support this.

This is greatly disappointing to me given the several major rural healthcare provisions that are including in this legislation. The labor share revision, the geographic physician payment adjustment, equalizing the Medicare disproportionate share payments, increasing home health services furnished in rural areas, critical access hospital improvements—these are all incredibly important provisions that I strongly support in order to help strengthen the health care system in rural areas. I cannot, however, vote in support of H.R. 1 with the extremely flawed prescription drug benefit included with these strong rural health provisions.

Mr. Speaker, I strongly support adding a voluntary prescription drug benefit to Medicare. I strongly believe that we must take action to provide relief for our nation's seniors. I simply do not believe, however, that H.R. 1 is the most effective way to do so. Tonight I will be voting in support of the substitute being offered by Mr. RANGEL and Mr. DINGELL.

In addition to including stronger rural provisions than those included in the Majority's bill, the substitute includes a guaranteed benefit of a $25 premium, a $100 deductible, 20% co-insurance, and a $2,000 catastrophic protection. The substitute also allows for lower drug prices by granting the Secretary of Health and Human Services the authority to use the collective purchasing power of Medicare's 40 million beneficiaries to negotiate lower drug prices. Also, the substitute grants access to generic drugs, and allows the safe re-importation of pharmaceuticals, providing further tools to seniors for gaining access to cheaper prescription drugs.

Perhaps most importantly, the substitute will not force seniors to leave traditional Medicare to get drug coverage. Nor will they be forced to join a private insurance plan that will restrict access to needed drugs, deny coverage for the medicine their doctor prescribes, or force them to change pharmacies.

Mr. Speaker, our seniors deserve a real prescription drug benefit, not the flawed benefit included in H.R. 1. I urge my colleagues to vote against H.R. 1 and support the substitute. Our seniors should not be forced into the unconscionable position of being forced to choose between medications and groceries any longer, and, unfortunately, H.R. 1 will not adequately address this situation.

Mr. SHAYS. Mr. Speaker, I rise in support of H.R. 1, the Medicare Modernization and Prescription Drug Act. I want to begin by appreciating the incredible time and energy that my colleague, NANCY JOHNSON, has put into crafting what I consider to be a good product, and thank her for her efforts.

When Medicare was created in 1965, the program's principal purpose was to help seniors pay for their hospital costs. Since that time, Medicare has not kept pace with how health care is delivered. Today, we are bringing this program into the 21st Century by including coverage for prescription drugs.

Our seniors need and deserve prescription drug coverage under Medicare. This legislation will give them tremendous assistance. After a $250 deductible, seniors will get 80 percent of their first $2,000 paid for by the program, catastrophic protection from any cost over $3,700, and discount on all their pharmaceutical costs from an Rx Drug Discount Card. The card will save beneficiaries between 10 and 25 percent on every purchase.

I believe this bill takes a positive step towards injecting competition into Medicare, but I regret we did not go further in reforming the program to ensure its solvency for future generations.

I also believe anything free, even health care, is over-utilized. I support the House proposal to add a small co-payment to home health care and to index Part B deductibles to inflation, and I support the Senate proposal to have seniors pay a portion of their catastrophic costs. This way, seniors have a greater incentive to get care because they need it, not just because it is offered.

Finally, we must be concerned with what this program will ultimately cost. It could go well over the $400 billion we budgeted and accelerate the program's financial demise if we are not vigilant.

There is a lot to like in the bill we hope to pass tonight, and the Senate has already passed a plan I can support. My hope is the House and Senate conferees will draft a final bill that takes the best approaches from each chamber and that we can ultimately send the President a Medicare prescription drug bill supported by both sides of the aisle. I urge my colleagues to support H.R. 1.

Mr. DAVIS of Illinois. Mr. Speaker, late last night, the House Rules Committee sent a terrible message to our Nation's seniors and hospitals. Two amendments I proposed were not allowed to pass onto the House floor. The first amendment would have stricken the language regarding the ''market basket'' index. Under the current bill hospitals would lose $12 billion over the next ten years. My amendment would have kept the funding streams toward hospitals level so that hospitals would not be forced to make difficult cuts in services and jeopardize patient care.

My second amendment would have assured that the prescription drug benefits we members of Congress enjoy would be comparable to those of Medicare beneficiaries. My colleagues in the Senate passed such an amendment, but the Members of the House Rules Committee seem reluctant to subject themselves to the very same benefits they would give our Nation's seniors. They have sent the clear message that these benefits are not good enough for them, the relatively young and healthy, but are adequate for our Nation's seniors and disabled persons.

Once again this Congress has proven that the Democratic process is not working. Not only are the voices of America's seniors not being heard, but neither are those of Members of Congress. As we go home to celebrate our Nation's independence, we will have to explain to our seniors that yes, a prescription drug bill passed, but it will not benefit them. It will not benefit middle America, it will not benefit the poor, it will not benefit those who are already struggling to buy their prescription drugs. It will only benefit those who can currently afford their drugs, afford to pay more for hospital services, and afford to pass this bill. Mr. Speaker, I oppose this rule and I oppose the underlying bill.

Mr. HOLT. Mr. Speaker, for forty years, the federal government has kept a promise to our nation's seniors. That promise is called Medicare, and it means that every senior will receive affordable, reliable health care in their later years.

Four years ago, I came to this Congress having made a promise to the seniors in my Congressional district—that I would work to bring Medicare into the twenty-first century by including coverage for prescription drugs. Coverage that, like the original Medicare program, is comprehensive, voluntary, universal, and reliable—without hampering the innovation that has brought us so many miraculous drugs over the past few decades.

Today I am voting to keep that promise by opposing a bill that would undermine the Medicare program itself. H.R. 1 purports to offer seniors coverage for the prescription drugs they rely on every day. Unfortunately, it falls far short when held up to the spirit and practice of Medicare.

The most distressing aspect of this bill, to me, to my constituents, and to the AARP, is that it takes the entire Medicare program down a short road to privatization. By the year 2010, Medicare would be converted to a voucher program with competition between managed care plans and traditional fee-for-service—only the deck would be stacked against the traditional plans. Seniors would find themselves have forced to enroll in managed care programs like the Medicare+Choice programs that have failed so miserably in central New Jersey.

Rather than giving seniors what they want and deserve—a reliable, affordable drug benefit under Medicare, this provision, glibly called ''premium support,'' will destabilize the program and lead to substantially higher costs for seniors who want to stay in traditional Medicare.

Yet another element of confusion comes from the bizarre ''donut hole'' in coverage under this bill. Seniors would find themselves paying 20 percent of drug costs up to $2000 in drug costs—then having no coverage until they reach $4900 in drug costs, when a catastrophic cap finally kicks in. Not only is this extremely convoluted, it ends up leaving seniors with a very paltry benefit. A beneficiary with $5000 in annual drug costs would pay nearly $4000 out of their own pocket!

This may be alarming to seniors who currently have no drug coverage. There are millions out there, however, who may think this debate won't really affect them because they already have coverage under their company's retiree benefit packages. I want them to know that the Republicans have quite a surprise in store for them.

If this bill passes, nearly one-third of employers currently offering retiree drug benefits—covering 11 million seniors—would drop that coverage. Retiree benefits would not count towards the beneficiary's out-of-pocket limit, making it almost impossible for seniors with retiree coverage to ever reach the catastrophic cap. So the bill actually discriminates against seniors with existing coverage and will have the practical effect of employers ending their benefits. This provision makes no sense—why on earth do we want to have less private sector drug coverage?

While I am disappointed with the underlying bill, I am pleased to see that the Rules Committee made the Dingell-Rangel substitute bill in order. This legislation would go a long way to fulfilling the promise I mentioned—it would provide a reliable, stable benefit under Medicare. Beneficiaries know exactly what they would pay—20 percent of drug costs up to $2000 in out-of-pocket costs with a defined premium of $25 per month and a defined deductible of $100.

Tonight, in this body, by passing H.R. 1 we could be bringing about the end of a program that served seniors so well. Instead, we should pass the Dingell-Rangel substitute. That is what seniors need and deserve.

Ms. CHRISTENSEN. Mr. Speaker, I rise in strong opposition to the Republican prescription drug bill, and in favor of the Dingell/Rangel Substitute.

We have been talking about a Medicare drug benefit for at least as long as I have been here—seven years. It is time to deliver. We owe it to our seniors who need it because their lives depend on it.

I have longed for the day when all people living in this country have reliable, comprehensive insurance coverage. Today we can bring this within the reach of every person on Medicare.

About 25 percent of my patients when I was in practice were on Medicare. Many could not get a full month's supply of medication because they could not afford it on their fixed income. We would try to make it up with samples, with medication that might not have been as effective but was within their price range, and better than nothing, and with a lot of prayer. It is probably the latter which got them through.

The bill, H.R. 1, as usual comes with a good sounding name, but true to form it does nothing good at all. Instead, it misleads the older Americans who have been looking to us for help.

We need a benefit that is truly a benefit—one that is affordable and fair—through a program they know, have used all along and trust;

It needs to be available to all benies without having to navigate through the maze of managed care.

And we need to make it reliable—no holes to fall through when they might need it most;

No dropping them like hot potatoes like happened with Medicare + choice.

Finally tonight, we have such a bill in the Democratic, Rangel/Dingell substitute.

In this bill, there are no slight of hands. What you see is what you get.

And our plan strengthens Medicare, while the Republican plan would slowly kill it.

No tricky numbers, no fancy words, just a simple, Medicare prescription drug plan. That is what the senior and disabled citizens have been asking for and that is what they deserve. It is what God-willing; I hope I would have when I am on Medicare.

I want for Medicare beneficiaries, who have played an important role in making this country what it is, and paved the way for all of us, and those who have special needs, what I want for my family and myself.

The Democratic substitute, developed under the leadership of JOHN DINGELL and CHARLES RINGELL, is the only bill before either body, which honors our seniors' gift to all of us.

Let us do the right thing. Reject the Republican bill and pass the Democratic substitute.

Mr. HINOJOSA. Mr. Speaker, I rise today in opposition to the Republican prescription drug bill. For years, our seniors have been begging for help to obtain affordable prescription drugs. Unfortunately, however, the bill before us today gives relief not to our vulnerable seniors, but to the large drug companies.

It forces Medicare patients into multiple private drug plans and out of Medicare. It undercuts seniors' collective purchasing power and enables the drug industry to maintain its unjustifiably high prices.

Seniors who live in rural and undeserved areas will find themselves without any coverage because insurance companies will not be required to serve them and are given no incentives to provide coverage. Because of a large coverage gap, over half of all seniors will still be required to pay thousands of dollars a year for prescription drugs as well as the program premiums.

Hidden in this bill is also another provision that will change the way cancer patients are treated and subject them to delays and reduced access to care.

By contrast, the Democratic plan offered by Mr. RANGEL would provide voluntary prescription drug coverage for all Medicare beneficiaries. The plan curbs drug costs by allowing this Secretary to use the collective bargaining power of Medicare's 40 million beneficiaries to negotiate lower drug prices.

I urge my colleagues to oppose the sham Republican proposal and support the Rangel substitute that provides real benefit to our Nation's seniors.

Ms. MILLENDER-MCDONALD. Mr. Speaker, I stand here with my colleagues tonight to talk about the need for affordable prescription drug coverage for women. Because women suffer more from chronic illnesses requiring medication than men do, they pay more out of pockets for medicine though their financial resources are often limited.

The proposed House bill would fail to offer meaningful prescription drug coverage to the millions of low-income women with incomes below the 135 percent poverty level who do not meet the requirements of asset tests. Also, the House bill would raise the amount of copayments that our country's poorest women Medicare beneficiaries are forced to pay.

Unlike the House bill, the Senate proposal, while not perfect, would be far more helpful to elderly women who range from 74 to 160 percent of the poverty level. Under the House bill, the out-of-pocket costs paid by elderly women will still make it difficult for them to get their much-needed prescriptions filled. If the House bill is enacted, our struggling women seniors who are in greatest need of assistance will receive up to 40 percent fewer prescriptions than those seniors who are able to afford private insurance. Our elderly women, who are among our most vulnerable citizens, deserve far better treatment than this. It is critical that as Members of Congress, we help women and all seniors by expanding Medicare to offer a prescription drug benefit that is universal, affordable, dependable, and voluntary. We can do no less than to offer elderly women access to adequate healthcare that they can afford and easily access.

Our Republican colleagues are offering a plan that gives no real guarantees or assistance to those who need quality prescription drug coverage the most.

Furthermore, the House plan would force seniors to purchase their own private insurance, a tactic that will benefit insurance companies, and not seniors. This is a catastrophe we can avoid if we craft the right policy to benefit our elderly now. When it come to our elderly women, we know that:

Women make up 58 percent of the Medicare population at age 65, and 71 percent of the Medicare population at age 85.

Overall, elderly women have more chronic health problems than elderly men do.

On average, women live another 19 years after retirement, while men typically live another 15 years after retiring.

Due to the obstacles they face in enrolling, almost half of elderly women with incomes under the poverty limit are not enrolled in Medicare.

As compared to married women, widows are four times as likely, and divorced or single women are five times as likely to live in poverty upon retiring.

Many elderly women survive on fixed incomes. Over half of the older women age 65 and above earn less than $10,000 annually, and three out of four earn under $15,000 yearly. In contrast to elderly men, older women age 65 and above earned $14,820 as compared to $26,543 for men in the same age group.

Once retired, women earn less than men because:

Women tend to save less than men do throughout their lives which decreases their lifetime earnings.

Elderly women usually have smaller Social Security benefits and pension incomes than men do.

Minority women are much more likely to earn less and live in poverty than are White women. Even when they have similar educational backgrounds, minority women tend to earn less money and own fewer assets.

The sad fact is, the older and poorer a woman is, the higher her out-of-pocket health care costs will be, and the more help an elderly woman requires, the less likely she is to receive assistance. As a nation, though we are facing a great economic crisis, we are still obligated to provide assistance to our most needy citizens. Let us take good care of our elderly women and men by not enacting a prescription drug policy that will force them to choose between either buying food or paying for necessary medication.

Mr. COSTELLO. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. I recently informed over 70,000 seniors in my district that I would not support legislation that would fundamentally change the nature of Medicare and provide a prescription drug benefit that relies solely on insurance companies. I am opposing the bill because it does just that.

Medicare has been a success because it provides guaranteed coverage for all elderly and disabled Americans. H.R. 1 would end Medicare as we know it and may particularly harm rural areas that depend on the traditional Medicare program. Beginning in 2010, H.R. 1 would force the Medicare fee-for-service program for doctors and hospitals visits to compete with private insurance plans. People who wanted to remain in traditional Medicare would find their premiums going up as other beneficiaries opted for bargain private insurance coverage. Seniors and the disabled would essentially be forced out of the traditional fee-for-service program and into some form of managed care.

In addition, the Republican approach does not guarantee the same benefits for all seniors. Seniors who live where hospitals and doctors negotiate lucrative contracts with managed care plans would have to pay more; seniors with higher incomes would have to pay more; seniors in rural areas would have fewer choices of doctors and pharmacies; and seniors with low incomes but with assets such as a savings account might get nothing at all. These provisions violate the central promise of Medicare: to provide a consistent, guaranteed benefit that allows everyone, no matter where they live, how much they have, or how sick they are, access to quality medical care.

Finally, H.R. 1 is flawed because it offers seniors an inadequate prescription drug benefit. I support a voluntary prescription drug benefit paid for by Medicare. I am committee to providing a comprehensive benefit that is affordable and dependable for all beneficiaries with no gaps or gimmicks in its coverage. The Senate is currently working on a prescription drug bill that provides a government fallback provision, providing Americans with more of a reliable, consistent benefit. The Senate is moving in the right direction and I am hopeful, progress will continue to be made when this legislation goes to conference.

H.R. 1 relies too heavily on the insurance industry to bring drug costs down and does not guarantee seniors access to the medicine prescribed by their doctor or that they can get prescriptions filled at their local pharmacy. Seniors deserve fair drug prices and a real, affordable prescription drug plan.

Mr. Speaker, for these reasons, I oppose H.R. 1. I urge my colleagues to do the same.

Mr. FILNER. Mr. Speaker, I rise today to discuss the prescription drug benefit proposal that my colleagues on the other side of the aisle have rammed through the legislative process. I rise to decry this bill because it does not give seniors what they deserve. It seems pretty simple to me: a prescription drug benefit under Medicare ought to work the same way that Medicare has always worked. That is, it is a guaranteed benefit for all seniors, no matter where they live, how ill they are, or what kind of illness they have.

This bill proposes to turn the prescription drug benefit over to HMOs and the private insurance industry. That means, for one thing, that premium prices are not guaranteed—the insurance industry would be able to charge what ever they wanted for the premium. In addition, it would be the insurance companies that get to decide which drugs would be covered. What this means for seniors is that there will not be a consistent, reliable program for all seniors is that there will not be a consistent, reliable program for all seniors across the country. Seniors in my district might pay higher premiums and get less coverage than their counterparts in other areas of the country. Or, they may get better coverage for lower premiums. We just don't know because it will be left up to the private insurance companies and the HMOs.

This bill also raises out-of-pocket costs for those who need the protection that Medicare had traditionally provided: the sickest and the poorest beneficiaries. In addition to the ''mystery'' premium, seniors will have to pay for the first $250 worth of drugs without any help from the Federal Government. After they have paid $250, they must pay 20 percent of all their drug costs. Once they reach $2,000 worth of medications, they must pay all of their drug costs until they reach $4,900 worth of drug costs. So, once they get to $2,000, in addition to the premium, the $250, the 20 percent copay, they must cover all of their prescription costs until they get to $4,900. That is quite a lot of money.

Allowing HMOs and private insurance companies to take over the Medicare Prescription Drug benefit also presents a problem for rural areas. A very large portion of my district is rural. Everyone knows that for private companies, the bottom line rules. Rural areas aren't as profitable for insurance companies, so there is less incentive for them to offer benefits in those area. This means that there will be fewer choices—if any choices at all—for seniors in rural areas.

In one fell swoop, this bill takes the great success story that is Medicare: Universal healthcare for all beneficiaries, and crushes it. Under this Republican bill, your benefits and your costs depend on your income, where you live and the whim of the insurance company or HMO that is running the program in your area.

Mr. Speaker, I have received many letters and calls from my constituents who are worried about this proposal. They know that this proposal will cost them more money, may not even be available to them if they live in rural areas, and will not cover all their medication needs—especially for those with diabetes or even cancer. I will read one example from my constituent, Edna Monk:

Dear Sir, I am writing my Senators and Representatives to plead our case regarding Medicare proposals that could endanger patent access to chemotherapy. I am a lung cancer survivor, age 71, and my husband, age 78, is now undergoing chemo, for liver cancer. Chemo drugs are required for my husband's quality of life now and MRI's have shown the tumors have diminished in size, so ''it's working!''

She goes on to say, ''We in the cancer community want one thing: for all critical cancer services, including chemotherapy and patient care services to be covered fully and fairly by Medicare.''

Mrs. Monk makes a good point. Services must be covered fully and fairly by Medicare. It does seniors no good to have unequal coverage of medications! That is why I cannot support the Republican bill and I urge my colleagues to vote against this poison pill for Medicare!

Mr. PASTOR. Mr. Speaker, I rise today in opposition to the Medicare Prescription Drug and Modernization Act. This bill, long heralded by the Republicans and the Administration as a comprehensive overhaul of the Medicare system, will do nothing to alleviate the harsh effect on our seniors of the high cost of prescription drugs. It only will continue to aggravate the cause of health care inflation.

Depsite all Republican claims to the contrary, the bill, which calls for private drug-only plans, would not make drugs affordable. It has no mechanism for keeping prices down, no negotiation for acceptable terms, no guarantee of defined and stable costs. Seniors would be at the mercy of private plans. They would lose their choice of doctors. They would be at risk of continuous coverage.

Private plans would only have to promise to stay in the program for one year. We've had these problems before with the Medicare Plus Choice program which failed to deliver its expanded benefits, leaving millions of seniors out on a limb.

Seniors have voiced their concerns. They fear the absence of provisions to limit drug prices and the lack of certainty about the future cost and coverage provided. Many seniors in rural areas are worried because they have no access to private plans and would have no ''fallback'' to offer coverage. Seniors are particularly concerned with the ''gap-in-coverage'' that means no coverage at all for drug spending between $2,000 and $5,100.

Instead of passing this plan which would privatize Medicare, we should support a plan that would establish a real Medicare prescription drug benefit within the Medicare program. The plan should be available to everyone regardless of income or place of residence. It should be voluntary and comprehensive. And, most importantly, it should be affordable.

The Medicare Prescription Drug and Modernization Act fills none of these requirements. Therefore, Mr. Speaker, I vote ''no'' on H.R. 1.

Ms. WOOLSEY. Mr. Speaker, this debate is a question of priorities, and it's a question of values. Under the Republican plan, after seniors have incurred $2,000 in prescription drug benefits, they will still pay a premium, but they better not expect anything in return. And why is that?

It's because just last week, the Republican leadership decided that they would rather eliminate estate taxes for millionaires than help seniors afford prescription drugs. They insisted on spending a total of $820 billion to help 8,000 millionaires. For almost the same cost, we could give millions of seniors a real prescription drug benefit.

Millionaires or millions of seniors? The Republicans give new meaning to the phrase ''better off dead.'' If you're rich and dead, Republicans don't want you to lose a dime. But if you're alive and can't afford the high cost of prescription drugs—well, good luck.

You might want to be dead. I dare my Republican colleagues to tell their mothers what they're doing to Medicare.

My priority is giving every American senior a real prescription drug benefit, like the one in the Democratic alternative. Oppose the Republican bill, support the Democratic alternative.

Mr. OBERSTAR. Mr. Speaker, Medicare, the most successful social service program since Social Security, will be dramatically transformed and, in the long run, unraveled by this Republican bill we are debating tonight.

Their plan will convert Medicare from a defined benefit plan to a defined contribution voucher plan. In plain English, it means that seniors will lose the guaranteed coverage and the security of knowing which benefits are covered. Instead of having predictability about Medicare premiums and copayments, seniors will essentially receive a voucher for services to cover the lowest-cost private insurance plan. If this plan does not pay for the services they need, seniors will have to cover the difference—which could be a big figure—out of their own meager income.

As a result, this untested, speculative health care experiment threatens to abandon all seniors, especially rural seniors. The Republican bill replaces Medicare with an illusory promise that private health insurance companies will offer health insurance polices in rural America. Under current law, health insurance companies have found it unprofitable to offer policies in rural America; worse, the Republican plan does not guarantee that rural seniors will have access to the same benefits as seniors in metropolitan areas enjoy.

Not only does this bill undermine Medicare, it fails to provide an affordable prescription drug benefit. I don't understand how the majority, on the one hand can justify trillion dollar tax cuts, and in the other hand, impose an arbitrary limit on Medicare and prescription drug benefits. To comply with this artificial limitation, the Republican plan offers a complicated and untested prescription drug benefit, with an enormous gap in coverage.

The Republican plan is difficult to explain, but let me try: it begins with uncertain private health insurance premiums; then, seniors must pay a $250 deductible before they receive any assistance, and there is a large coverage gap, the ''hole'' in the doughnut, where seniors will be paying premiums but receiving no assistance at all. Seniors first have to spend $250 a year, then they will pay 20 percent co-insurance for up to $2,000 in drug costs. However, no assistance would be provided between $2,000 and $5,100 in drug spending, forcing seniors to pay $3,100 out-of-pocket in drug costs. This plan is as unfair as it is complicated and costly to older Americans living on fixed incomes.

In contrast, the Democratic plan is guaranteed, defined, dependable, and understandable. It sets a premium of $25 a month; a $100 per year deductible; a 20 percent co-insurance payment for beneficiaries, with Medicare paying 80 percent; and a limit of $2,000 in out-of-pocket costs per beneficiary per year.

Health care is essential in greater Minnesota. The hospitals in many small communities throughout northern and northeastern Minnesota are the major employer in town, and the health care they offer is critical for economic development and tourism. The Rangel/Dingell bill offers a substantial improvement in payments to the hospitals and doctors in rural Minnesota who provide those critical health care services.

In particular, I am please that the Democratic Substitute includes numerous provisions to improve reimbursement for rural providers. The increased funding for low-volume, ''critical access'' and ''sole community'' hospitals, rural home health and ambulance providers, and rural physicians adds up to very significant improvements for hospitals in my district, and will assure their continued viability for years to come.

To be specific, the Democratic bill eliminates the 35-mile rule presently in place for Critical Access Hospital ambulance services. That improvement would save the hospital in Ely, Minnesota, and would strengthen ambulance services at nine other Critical Access Hospitals in my district.

The Democratic plan would provide an additional $6 billion for all rural ambulance providers by increasing payments for ambulance services. The increases we propose would ensure the financial solvency of St. Mary's Life Flight, enabling it to continue assisting, for example, people who are injured while vacationing in the Boundary Waters Canoe Area Wilderness.

On the whole, rural health care providers plan are better served, better funded, and treated more fairly under the Democratic plan, which also has the advantage of preserving Medicare. For that reason, I will be supporting the Rangel/Dingell bill.

Mr. BURR. Mr. Speaker, as vice chairman of the Energy and Commerce Committee and a member of the Health Subcommittee, I have worked on Medicare prescription drug legislation for more than four years. The House has passed Medicare prescription drug legislation twice and I voted for both bills.

Mr. Speaker, I will not vote for this bill.

The $400 billion allocated for the Medicare drug benefit is not being spent widely under this legislation. High-income Medicare beneficiaries like Warren Buffett are subsidized 73 percent by the Federal government for their drug-only insurance plans. Low-income seniors who are not dually eligible have no cost-sharing assistance for their drug spending between $2,000 and $3,500. The Secretary is commanded to negotiate with insurance companies who will game the system to receive a 99.99-percent subsidy when 73 percent would have been fine. Mr. Speaker, that's not a negotiation—the insurance company will hold all of the cards. No money is being spent on a fallback plan. Seniors in rural areas of North Carolina will not have drug coverage if insurance companies refuse to offer a plan, even when the companies are bribed with an almost no-risk contract. This bill would benefit insurance companies, not extend a benefit to our Nation's seniors.

Yet insurance companies do not want any part of this legislation. For four years insurance companies have been telling Congress

that they do not want to insure Medicare beneficiaries' drug expenditures, but we keep throwing money at them in the hope that they will finally say yes. The premium subsidy used to be 67 percent, now it is 73 percent and Congress demands that it grow to 99.99 percent if need be. At the end of the day, who are we kidding? Of course it will be 99.99 percent.

Our problem is that the Congressional Budget Office has written this bill. The last time I checked, Mr. Speaker, it was not the job of the Congressional Budget Office to write highly technical and important health care legislation. But policymakers are so convinced that a purely insurance-based product will work that they are willing to follow CBO's instructions and tweak the product one thousand different ways—and cut provider payments at the same time—to fit it under some magical budget ceiling. If CBO is wrong in its estimate, and this drug benefit costs more than $400 billion, our entire health care system will be at risk. This is not wise health care policy.

Where do my colleagues think the extra money is going to come from? When CBO realizes that their estimated insurance penetration rate was off by 10 percent that money will come out of future physician, hospital, nursing home, and home health care reimbursement rates. If only 85 percent of seniors sign up for drug coverage and plans' subsidies skyrocket, that money will come out of Food and Drug Administration modernization efforts, National Institutes of Health research, and bioterrorism preparedness. Congress is working with a limited pot of money, but we are promising a defined benefit. Obviously, the experiences of the private sector have taught us nothing.

If Congress listened to the private sector, we would mirror the success of defined contribution plans and individual empowerment by offering choice. Seniors could choose between twenty different discount drug cards based on the cards' formularies, pharmacy networks, and drug discounts. The government would set up accounts and contribute money to those accounts based on the seniors' needs. Seniors, their family members, friends, and former employers could put money into the accounts and receive a tax deduction. And insurance companies would offer catastrophic coverage that is subsidized by the federal government for low-income seniors. Unfortunately, that plan is not on the floor today.

Mr. Speaker, I wanted to be able to come to the floor today and vote for a good Medicare prescription drug benefit because of the bills passed by the House in the last 3 years this one has the greatest chance of actually becoming law. But not only does this bill contain a bad drug benefit, it also contains a cut in the overall hospital market basket update, a new home health copayment, multiple reimportantion provisions that will harm our Nation's drug supply, and a reduction in the overall reimbursement rate for physicians such as oncologists and rheumatologists who administer Part B drugs. It also constitutes a threat to the very future of our health care system.

I can only compare my feelings today to my experience in 1997, when I voted against the Balanced Budget Act. I was one of only 32 Republicans who opposed that bill. I came to Congress to balance the federal budget, but in the end I could not vote for the legislation because of the drastic and thoughtless cuts in Medicare reimbursements. Since 1997, Congress has done nothing substantive in Medicare except try to fix the damage done under the BBA. I cannot support this legislation that builds on and magnifies those 6-year-old mistakes.

I regret that I cannot and will not vote for this legislation.

Mr. UDALL of Colorado. Mr. Speaker, I want to support a Medicare prescription drug bill, but I can't support the one we are considering today. It is inadequate, unreliable, will force seniors into HMOs, and will endanger drug benefits that many seniors get through their retirement plans. In fact, instead of drafting a Medicare drug benefit bill, the Republican Majority has used this opportunity to try to end Medicare as we know it.

I have long believed that Congress should act to help seniors with their prescription drug expenses. Nearly everyone agrees that Medicare should be updated with a drug benefit; it is the right and sensible thing to do. How we design that benefit is where the rub is. I had hoped that we would vote on a bill similar to the one in the Senate because I think it's a good start toward building a workable, financially sound prescription drug benefit. But the House bill is not the same as the Senate bill.

First, I think Congress should give seniors greater choice in coverage, however, it should provide an equal prescription drug benefit to all beneficiaries, regardless of whether they enroll in a private health plan or traditional fee-for-service Medicare. We shouldn't force seniors into managed care, which I believe this bill will do by opening the traditional Medicare program up to competitive bidding against private insurers in 2010.

Second, the House bill does not include an important ''fallback'' provision that requires that traditional Medicare would step in as a backup if private insurers show no interest in selling drug plans in a particular area. Currently, private plans don't exist in many parts of the country, including many smaller cities, rural and mountain areas in Colorado. I've heard from many seniors in my district who have been dropped from their Medicare HMO and are now having trouble finding a doctor. In addition, 88 percent of all Medicare beneficiaries are enrolled in traditional Medicare. So, without this ''fallback'' safety net provision, seniors would have no coverage in regions where insurers say it's unprofitable to provide it, especially rural areas.

Taken together, I think these provisions undermine the traditional Medicare program. By opening traditional Medicare to competitive bidding and with no fallback mechanism, I fear that our country will revert to the time before Medicare was established in 1965 when private insurers wouldn't provide affordable coverage to seniors. That's a step backward, not a step forward, in fixing Medicare.

I also have problems with the home health copayment provision in the bill, which I believe will discourage seniors from accessing home health care, which is more cost effective than accessing treatment an emergency room or a skilled nursing facility. And I am concerned that opening durable medical equipment to competitive bidding will give seniors less choice and put many small businesses out of business.

On top of everything, this 692-page bill was introduced at midnight last night. How can anyone know what's in it, except the people who wrote it? Our seniors deserve greater respect.

Mr. Speaker, it is misguided at best that Medicare will pay for a senior's care following a stroke but will not pay for the anti-hypertension drugs that prevent them. The time is ripe to pass a Medicare prescription drug benefit, but not this one. I regret I can't support it. I hope that a bill can be worked out in conference that I can support. We need to put ideological and partisan politics aside and get it done this year.

Mr. CROWLEY. Mr. Speaker, I rise in support of the Democratic substitute because this bill meets the 4 basic tenets that any prescription drug plan under Medicare should absolutely provide for.

First, it means lower drug prices. The House Democratic bill allows HHS to negotiate lower drug prices. The Republican bill, unfortunately, does not.

Second, this bill guarantees coverage under Medicare.

Because of this, a senior knows what his premium, cost-sharing level, and catastrophic coverage is. The Republican bill has no such guarantees.

Third, this bill provides coverage for all drugs prescribed by a doctor. Under the Republican bill, a payer could deny coverage for a drug if the payer decides to not include it in its formulary.

Fourth, this bill has no gaps in coverage. Under the Democratic plan, when a senior has spent $2,000 on drugs, the government picks up the remaining costs.

When a senior has spent $2,000 under the Republican plan, they're dropped. They get zero coverage until they've spent $4,900.

The Republican bill does not simply have one big problem. It has several huge problems.

Only the Democratic substitute provides seniors in my district guaranteed, quality coverage. I urge an ''aye'' vote.

Mr. BUYER. Mr. Speaker, I rise in opposition to the bill, H.R. 1, the Medicare Prescription Drug and Modernization Act.

I fully support the effort to provide prescription drug coverage to Medicare beneficiaries. The successes in modern medicine that we see today can be partly attributed to the advent of safer and more effective pharmaceutical drug therapy. Illnesses and serious diseases that often required hospitalization 40 years ago, when Medicare was created, can now be treated with outpatient care and pharmaceuticals. This is a testament to the many scientists in numerous companies that toil daily to find compounds to treat and manage disease. The pharmaceutical industry is a testament to the free market system of the United States that rewards hard work, initiative, and enterprise. As the great minds of the world push the bounds of modern science, new discoveries in pharmacology lead to the betterment of mankind.

While H.R. 1 has some positive features, including addressing medical doctor and dentist provider reimbursement concerns and regulatory impediments, an insurance product built and guaranteed by the government is not the approach to provide a drug benefit under Medicare.

And, make no mistake, we MUST get it right. I have serious levels of concern.

First, the legislation before us has the government assuming 73 percent of the risk of offering the insurance, 43 percent of the initial

benefit and 30 percent of reinsurance retrospectively. This is the floor! We must all understand that the taxpayer's exposure to risk can only increase. The bill permits the government to assume more risk, up to 99.9 percent if it is necessary to entice an insurance product into a region. And this is an unknown factor. We simply do not, nor cannot, know what this provision will cost the taxpayers.

Today, Medicare already consumes nearly 12 percent of the federal budget. It is expected to be 30 percent or 35 percent of the federal budget in 2030 without the addition of prescription drugs, or any other benefit. It is irresponsible of this Congress to simply add a prescription drug benefit without also addressing the budgetary impact of this benefit. H.R. 1 leaves the federal budget and the taxpayers exposed to unknown expenditure levels in the future. I do not believe that this drug bill will remain within the proposed budget of $400 billion over the next 10 years.

Second, there is no provision in the House bill on how to provide a benefit to seniors in areas where two insurance products are not available in January 2006. It is simply neither realistic, nor fair, for seniors in one region to have products available and seniors in another region to not have choice because two plans have not been forthcoming.

Furthermore, I am adamantly opposed to the proposal by some, especially in the other body, that the government provide this coverage. This will only lead to the government determining what prescription drugs a senior can have and ultimately the imposition of price controls that will have a chilling effect upon research and development of pharmaceutical therapies.

Third, the premium charged to seniors for the drug-only insurance plan is estimated to be $35 per year initially. This premium number is not found in the bill—it is an estimate by the Congressional Budget Office. What if it is more? Will seniors decide that this premium is worth the benefit they will receive under a drug insurance plan? There will be a great deal of kitchen table math being done by seniors in 2005 to decide whether this new benefit meets their drug needs and their wallet realities.

I am also concerned about a number of modifications made under the bill to reimbursement for providers and to the last minute inclusion of language regarding the Patent Term Restoration Act, the so-called Hatch-Waxman legislation. Although some very necessary provider reimbursement changes were made in the bill, particurlary regarding doctors and rural areas, nonetheless, I am concerned about the changes to the market basket update for hospitals, as well as the changes to skilled nursing facilities and home health care providers. In addition, I share the concern of others regarding the sufficiency of the reimbursement to oncologists. It is very true that the Congress needed to address the use of the ''average wholesale price,'' which was neither average nor wholesale, and left Medicare beneficiaries paying 20 percent of an inflated drug price, but oncologists need to be reasonably compensated for the level of care they provide to Medicare patients. I am not convinced that this has been sufficiently addressed.

I also have grave reservations over the inclusion of provisions regarding patent term and generic drugs, the changes to the Hatch-Waxman law. Initiating more litigation of patent rights is not conducive to encouraging innovation in pharmaceuticals. Unfortunately, this is exactly what this provision will do.

The vast majority of seniors have drug coverage today through either an existing government program or through the private sector. However, 27 percent of seniors have nothing. These seniors pay the highest prices when they go to the pharmacy because they have no means to bargain for lower costs. These seniors also tend to be those between 100 percent and 175 percent of the federal poverty level (FPL). A Medicare drug benefit should not displace existing coverage and should address the needs of those seniors who do not have coverage.

The government should encourage employers, families and others to help seniors with the purchase of expensive prescription drugs. It is time that we admit that no proposal that comes to the House floor that meets the budget requirements will fully address all the prescription drug requirements of seniors. Every plan will have a ''so-called donut hole.'' There should be a way to tackle this without putting our heads in the sand and expecting it to simply ''work out.''

We live by a system of checks and balances. We run into the limitations with everything that we do. How can we then create a system that is dependent upon the unknown? The government's assistance to beneficiaries should be a defined contribution. This type of benefit would be manageable and known.

I am committed to providing a prescription drug benefit for seniors. Seniors should have access to the same mechanisms that are available in the private sector to drive down costs and improve health care services.

Along with four of my colleagues on the Energy and Commerce Committee, we submitted legislation, that would address these issues and provide a prescription drug benefit under Medicare. I testified before the Rules Committee to request a vote on our bill. The request was denied. This benefit would have been delivered through a prescription drug discount, or value, card that would be available to all seniors on a voluntary basis for an annual $30 fee. This is an approach that has been recommended by the President.

Any entity qualified by the Centers for Medicare and Medicaid Services could offer a drug value card to seniors. Card issuers would negotiate with pharmaceutical manufacturers for discounts on drug utilizing the same techniques that are found in the marketplace today. These discounts would range from 15 percent to 35 percent of current retail prices. The competition among these card issuers would result in attractive offerings to beneficiaries.

Recognizing that some beneficiaries need financial assistance to pay for prescription drugs, this legislation would tie the drug value card to an account to which the federal government would provide assistance related to the income of the beneficiary. Others could add contributions on a tax preferred basis up to $5,000 for a beneficiary and family; and $5,000 for an employer. Non-profit organizations, like local churches, and State pharmaceutical assistance programs could add contributions to the accounts. Contributions on the accounts would roll over from year to year.

Protection from catastrophic drug expenses would also be offered at $10,000 through the private sector, with federal subsidies on the premium for those with low incomes.

In my opinion, this delivery mechanism for a prescription drug benefit works best for the beneficiary, and best for the taxpayers. Beneficiaries would have access to negotiated discounts and some financial assistance to buy drugs. The taxpayers would have a defined contribution that could be planned from year to year in the federal budget.

My colleagues, this has been a long road for us all. But, it is nothing compared to what could happen if Congress gets this wrong. Please be mindful of our obligations to our nation, not just to seniors.

It is my opinion that Congress needs to grasp this opportunity to provide a prescription drug benefit with a full appreciation of the duty and responsibility this nation has to our seniors, taxpayers, and future generations. To do anything less, we break the trust of all Americans.

Because the margin for error is so thin, my hope is that the majority is right. However, my intellect and instincts tell me that this bill will not fulfill the desired result. I must vote against final passage of this measure.

Mr. PAUL. Mr. Speaker, while there is little debate about the need to update and modernize the Medicare system to allow seniors to use Medicare funds for prescription drugs, there is much debate about the proper means to achieve this end. However, much of that debate is phony, since neither H.R. 1 nor the alternative allows seniors the ability to control their own health care. Both plans give a large bureaucracy the power to determine which prescription drugs senior citizens can receive. Under both plans, federal spending and control over health care will rise dramatically. The only difference is that the alternative puts seniors under the total control of the federal bureaucracy, while H.R. 1 shares this power with ''private'' health maintenance organizations and insurance companies. No wonder supporters of nationalized health care are celebrating the greatest expansion of federal control over health care since the Great Society.

I am pleased that the drafters of H.R. 1 incorporate regulatory relief legislation, which I have supported in the past, into the bill. This will help relieve some of the tremendous regulatory burden imposed on health care providers by the Federal Government. I am also pleased that H.R. 1 contains several good provisions addressing the congressionally-created crisis in rural health and attempts to ensure that physicians are fairly reimbursed by the Medicare system.

However, Mr. Speaker, at the heart of this legislation is a fatally flawed plan that will fail to provide seniors access to the pharmaceuticals of their choice. H.R. 1 provides seniors a choice between staying in traditionally Medicare or joining an HMO or a Preferred Provider Organization (PPO). No matter which option the senior selects, choices about which pharmaceuticals are available to seniors will be made by a public or private sector bureaucrat. Furthermore, the bureaucrats will have poor to determine the aggregate prices charged to the plans. Being forced to choose between types of bureaucrats is not choice.

Thus, in order to get any help with their prescription drug costs, seniors have to relinquish their ability to choose the type of prescriptions that meet their own individual needs! The inevitable result of this process will be rationing,

as Medicare and/or HMO bureaucrats attempt to control costs by reducing the reimbursements paid to pharmacists to below-market levels (thus causing pharmacists to refuse to participate in Medicare), and restricting the type of pharmacies seniors may use in the name of ''cost effectiveness.'' Bureaucrats may even go so far as to forbid seniors from using their own money to purchase Medicare-covered pharmaceuticals. I remind may colleagues that today the federal government prohibits seniors from using their own money to obtain health care services that differ from those ''approved'' of by the Medicare bureaucracy!

This bill is even more pernicious when one realizes that this plan provides a perverse incentive for private plans to dump seniors into the government plans. In what is likely to be a futile effort to prevent this from happening, H.R. 1 extends federal subsidies to private insurers to bribe them to keep providing private drug coverage to senior citizens. However, the Joint Economic Committee has estimated that nearly 40 percent of private plans that currently provide prescription drug coverage to seniors will stop providing such coverage if this plan is enacted. This number is certain to skyrocket once the pharmaceutical companies begin passing on any losses caused by Medicare price controls to private plans.

Furthermore, these private plans will be subject to government regulations. Thus, even seniors who are able to maintain their private coverage will fall under federal control. Thus, H.R. 1 will reduce the access of many seniors to the prescription drugs of their choice!

Setting up a system where by many of those currently receiving private coverage are hired into the government program exacerbates one of the major problems with this bill: it hastens the bankruptcy of the Medicare program and the federal government. According to Medicare Trustee, and professor of economics at Texas A&M University, Tom Saving, the costs of this bill could eventually amount to two-thirds of the current public-held debt of $3.8 trillion! Of course, estimates such as this often widely underestimate the costs of government programs. For example, in 1965, the government estimate that the Medicare Part B hospitalization program would cost $9 billion in 1990, but Medicare Part B costs $66 billion in 1990!

This new spending comes on top of recent increases in spending for ''homeland security,'' foreign aid, federal education programs, and new welfare initiatives, such as those transforming churches into agents of the welfare state. In addition we have launched a seemingly endless program of global reconstruction to spread ''democratic capitalism.'' The need to limit spending is never seriously discussed: it is simply assumed that Congress can spend whatever it wants and rely on the Federal Reserve to bail us out of trouble. This is a prescription for disaster.

At the least, we should be debating whether to spend on warfare or welfare and choosing between corporate welfare and welfare for the poor instead of simply increasing spending on every program. While I would much rather spend federal monies on prescription drugs then another unconstitutional war, increasing spending on any program without corresponding spending reductions endangers our nation's economic future.

Congress further exacerbates the fiscal problems created by this bill by failing to take any steps to reform the government policies responsible for the skyrocketing costs of prescription drugs. Congress should help all Americans by reforming federal patent laws and FDA policies, which provide certain large pharmaceutical companies a government-granted monopoly over pharmaceutical products. Perhaps the most important thing Congress can do to reduce pharmaceutical policies is liberalize the regulations surrounding the reimportation of FDA-Approved pharmaceuticals.

As a representative of an area near the Texas-Mexico border, I often hear from angry constituents who cannot purchase inexpensive quality imported pharmaceuticals in their local drug store. Some of these constituents regularly travel to Mexico on their own to purchase pharmaceuticals. It is an outrage that my constituents are being denied the opportunity to benefit from a true free market in pharmaceuticals by their own government.

Supporters of H.R. 1 claim that this bill does liberalize the rules governing the importation of prescription drugs. However, H.R. 1's importation provision allows the Secretary of Health and Human Services to arbitrarily restrict the ability of American consumers to import prescription drugs—and HHS Secretary Thompson has already gone on record as determined to do all he can to block a free trade in pharmaceuticals! Thus, the importation language in H.R. 1 is a smokescreen designed to fool the gullible into thinking Congress is acting to create a free market in pharmaceuticals.

The alternative suffers from the same flaws, and will have the same (if not worse) negative consequences for seniors as will H.R. 1. There are only two differences between the two: First, under the alternative, seniors will not be able to choice to have a federally subsidized HMO bureaucrat deny them their choice of prescription drugs; instead, seniors will have to accept the control of bureaucrats at the Center for Medicare and Medicaid Services (CMS). Second, the alternative is even more fiscally irresponsible than H.R. 1.

Mr. Speaker, our seniors deserve better than a ''choice'' between whether a private or a public sector bureaucrat will control their health care. Meaningful prescription drug legislation should be based on the principles of maximum choice and flexibility for senior citizens. For example, my H.R. 1617 provides seniors the ability to use Medicare dollars to cover the costs of prescription drugs in a manner that increases seniors' control over their own health care.

H.R. 1617 removes the numerical limitations and sunset provisions in the Medicare Medical Savings Accounts (MSA) program. Medicare MSAs consist of a special saving account containing Medicare funds for seniors to use for their routine medical expenses, including prescription drug costs. Unlike the plans contained in H.R. 4504, and the Democratic alternative, Medicare MSAs allow seniors to use Medicare funds to obtain the prescription drugs that fit their unique needs. Medicare MSAs also allow seniors to use Medicare funds for other services not available under traditional Medicare, such as mammograms.

Medicare MSAs will also ensure that seniors have access to a wide variety of health care services by minimizing the role of the federal bureaucracy. As many of my colleagues know, an increasing number of health care providers have withdrawn from the Medicare program because of the paperwork burden and constant interference with their practice by bureaucrats from the Center for Medicare and Medicaid Services. The MSA program frees seniors and providers from this burden, thus making it more likely that quality providers will remain in the Medicare program!

There are claims that this bill provides seniors access to MSAs. It is true that this bill lifts the numerical caps on Medicare MSAs; however, it also imposes price controls and bureaucratic requirements on MSA programs. Thus, the MSAs contained in this bill do nothing to free seniors and health care providers from third party control of health care decisions!

Mr. Speaker, seniors should not be treated like children by the federal government and told what health care services they can and cannot have. We in Congress have a duty to preserve and protect the Medicare trust fund. We must keep the promise to America's seniors and working Americans, whose taxes finance Medicare, that they will have quality health care in their golden years. However, we also have a duty to make sure that seniors can get the health care that suits their needs, instead of being forced into a cookie cutter program designed by Washington, DC-based bureaucrats! Medicare MSAs are a good first step toward allowing seniors the freedom to control their own health care.

Finally, Mr. Speaker, I would like to comment on the procedure under which this will was brought before the House. Last week, the committees with jurisdiction passed two separate, but similar Medicare prescription drug bills. In the middle of last night, the two bills were merged to produce H.R. 1. The bills reported out of Committee were each less than 400 pages, yet the bill we are voting on today is 692 pages. So in the middle of the night, the bill mysteriously doubled in size! Once again, members are asked to vote on a significant piece of legislation with far reaching effects on the American people without having had the chance to read, study, or even see major portions of the bill.

In conclusion, Mr. Speaker, both H.R. 1 and the alternative force seniors to cede control over which prescription medicines they may receive. The only difference between them is that H.R. 1 gives federally funded HMO bureaucrats control over seniors' prescription drugs, whereas the alternative gives government functionaries the power to tell seniors which prescription drug they can (and can't) have. Congress can, and must, do better for our Nation's seniors, by rejecting this command-and-control approach. Instead, Congress should give seniors the ability to use Medicare funds to pay for the prescription drugs of their choice by passing my legislation that gives all seniors access to Medicare Medical Savings Accounts.

Mr. THORNBERRY. Mr. Speaker, health care is an important but complex issue for Congress and for America's seniors. Two facts, however, seem clear:

One fact is that Medicare is currently headed toward financial collapse. The last report of the Medicare trustees shows that in nine years the income of the Medicare trust fund will not be enough to cover its expenses. After that, the problem gets much worse with the retirement of the baby boom generation.

A second clear fact is that Medicare was enacted in 1965 and has been largely unchanged since then. It does not reflect modern

medical practices, including our reliance upon prescription drugs. If we were designing a new federal health care program for seniors today—rather than in 1965 when Medicare was created—we would unquestionably include some form of prescription drug coverage.

Our objective then should be to update and strengthen Medicare so that it does a better job of providing health care for seniors and at the same time put Medicare on a sound financial footing so that it can be sustained through the baby boom generation retirement.

This bill takes some steps in that direction. It contains some reforms that improve Medicare and give beneficiaries more control over their health care. It also adds prescription drug coverage, and there are too many seniors in my district who are not able to afford the prescription medicines they need, forcing them either to do without and become sick or to sacrifice other necessities of life.

I am gravely concerned, however, that the reforms take too long to implement and that the new drug benefit will cost far more than expected. Without changes, this bill may add a major new benefit to Medicare but, at the same time, hasten the day of its financial collapse.

At the same time if we do nothing, we are guaranteeing that Medicare will not survive for long. The alternative proposals are far more expensive and are fiscally irresponsible.

I have other concerns with this bill, such as the reductions in payments for cancer treatments. Today, however, I will vote to send the House bill to conference with the Senate. I strongly urge that improvements be made to ensure Medicare solvency and to improve the quality of health care for America's seniors. We can do better. If improvements are not made, I will not be able to support the final conference report.

Mr. KIND. Mr. Speaker, providing affordable Medicare prescription drug coverage for our nation's seniors is one of the most pressing issues facing our country today. Even though the elderly use the most prescriptions, more than 75 percent of seniors on Medicare lack reliable drug coverage. It is time to modernize Medicare to reflect our current health care delivery system. The use of prescription medications is as important today as the use of hospital beds was in 1965 when Medicare was created.

I have heard from a number of seniors in western Wisconsin regarding the problems they have paying for prescription drugs. One woman from Deer Park, Wisconsin, a small town in my district, wrote to me and said:

My medication is $135.00 per month. Fortunately my husband is not on any medication. If we both were not working part-time, I guess that we would have to make a choice between food and Medication—does one eat to survive or take the medication for a ''long and happy life''?

What is to happen to this couple if the husband falls ill and has high drug costs too?

The cost of prescription medicines should not place financial strains on seniors that would force them to choose between buying drugs and buying food. We need to make prescription medicines affordable and accessible to all of our seniors.

I came to Congress to work toward a real solution to this problem. Unfortunately, today's debate is a sham. We will not have the opportunity to discuss this issue in a fair and open process. There were several alternatives presented at the Rules Committee late last night and they should be debated on the floor today. The majority, however, chose to dedicate only one day to this debate and allowed only one alternative and no amendments to be made in order. Our Nation's seniors deserve better. They deserve an open process, but the Republican leadership has failed to deliver this.

The Leadership has also failed seniors with their prescription drug proposal. The Republican plan is doomed to fail because the plan relies on health insurance companies to offer drug only policies which they have said they won't offer. Further, there is no fall back option. So, if insurance companies won't offer these policies, how will seniors actually obtain prescription drug coverage under the leadership plan?

Providing a drug benefit through private plans could be problematic, specifically for folks living in rural and small communities. There are no requirements as to what has to be covered and the coverage may vary from area to area depending on the plan. Because is there is no guaranteed benefit, Wisconsin may end up on the short end of the stick like we have in the past under Medicare.

The biggest problem with the leadership bill is the fact that it will fully privatize Medicare in 2010. This is a radical provision that will be the demise of the traditional Medicare program on which our seniors have depended for nearly 40 years. In 2010, seniors will be given a lump sum to purchase health isuruance, including traditional Medicare. There is concern that the healthy seniors will leave traditional Medicare and the premiums will increase dramatically, up to 47 percent. In addition, under the leadership bill, each local area will have a different premium for fee-for-service Medicare. For example, seniors in Wisconsin might have to pay more to enroll in fee-for-service Medicare than seniors in Florida. This is a drastic departure from Medicare's fundamental principle that seniors across the country pay the same premium for the fee-for-service benefit.

We must provide a real solution to the problem of prescription drug coverage for our seniors. The Republican plan falls woefully short.

All of the Democratic alternatives offered at the Rules Committee would be better than the leadership bill. One proposal, the Medicare Rx NOW Act, is a simple straightforward plan that provides assistance to the seniors most in need, those with low incomes and seniors with high drug costs. This proposal builds on the Medicare program seniors know and provides them with a guaranteed benefit for no additional premium.

Another proposal put forward by the Blue Dogs is based on the bipartisan Senate bill. Unlike the House bill, this proposal includes a fall back provision to ensure that all seniors would have access to a prescription drug plan. In addition, this bill does not include the privatization components of the leadership plan.

In addition, both of these alternatives provide substantial improvements to Medicare payments for rural providers. Both pieces of legislation include equalizing the disproportionate share hospital payments for rural hospitals, an increase in the bed limit for critical access hospitals, and a geographic adjustment for rural physicians. None of these provisions are included in the leadership's bill.

It is unfortunate that the Republican leadership has squandered an excellent opportunity to try and solve the problem of prescription drug coverage in a bipartisan fashion. Instead they have steamrolled ahead and present our nation's seniors with an unworkable solution to a grave problem. I urge my colleagues to reject this flawed proposal.

Mr. RAMSTAD. Mr. Speaker, I rise in strong support of the Medicare Prescription Drug and Modernization Act.

Today is an historic day. Congress is finally delivering on our promise to create a meaningful and long overdue prescription drug benefit for Medicare seniors and people with disabilities.

This bill means seniors will no longer have to choose between purchasing life-savings drugs or the basic necessities of food and housing.

In addition to this important new prescription drug benefit, the bill modernizes and improves Medicare to give seniors better choices and greater access to state-of-the-art health care.

I am grateful for the many important provisions in this package from my Medicare Innovation Responsiveness Act (H.R. 941), which will increase seniors' access to lifesaving medical technology.

As founder and co-chair of the Medical Technology Caucus, I have seen first-hand the incredible advances that medical technology and prescription drugs have made to treat and cure debilitating conditions. The current Medicare system is crying out for reform with its failure to incorporate these critical improvements.

Currently, seniors and people with disabilities face unconscionable delays of up to five years before Medicare provides access to technology that can literally be a matter of life or death.

The bill before us incorporates many of the reforms I have proposed in Medicare's coverage, coding and payment process that will speed access to lifesaving technology.

Thanks to this legislation, we are finally tearing down barriers that discourage innovation and deny America's seniors the medical technologies they desperately need. Seniors have waited too long for access to the same treatment options as other Americans.

In addition to the excellent work and leadership of Chairman THOMAS and Chairman JOHNSON, I want to thank two unsung staff heroes—John McManus and Deb Williams—who have worked so tirelessly on these provisions.

I am also pleased the bill includes H.R. 841, legislation I introduced with Mr. CARDIN to break down regulatory barriers facing specialized Medicare+Choice plans that serve the frail elderly.

Mr. Speaker, this package of reforms will improve the lives of our seniors and generations to come who count on Medicare. I urge my colleagues to support this landmark legislation and deliver on our promise to modernize and strengthen Medicare.

Mr. BACA. Mr. Speaker, I rise in opposition to H.R. 1, the Medicare Prescription Drug & Modernization Act of 2003.

This Republican plan is bad for seniors! It's bad for Hispanics! And it's simply bad for the American people!

For millions of Americans, this plan will replace traditional Medicare with vouchers that won't guarantee benefits.

It forces seniors into risky HMO plans and new private fee-for-service plans that will not cover all of seniors' costs!

Forty-seven percent of seniors in Medicare will have a $1,900 gap in their drug coverage. How are our seniors supposed to make up for that gap?

How are our parents and grandparents going to afford that! Most seniors are on fixed incomes with nothing to spare!

Forty percent of poor and disabled seniors won't get the additional help they need to pay deductibles and premiums. 40 percent.

This plan will not give taxpaying pregnant women and children benefits!

It will not help the twenty million Hispanics without Health insurance!

And it will not help our parents and grandparents pay for their medicines!

We must take care of our seniors! We must not gamble with their health and well-being. Seniors deserve to be protected in a safe and fair healthcare plan.

In my district, San Bernardino, California, seniors are boarding buses to Tijuana so they can afford to buy prescription drugs.

Our seniors have to go all the way to Mexico to get the life-saving medicine they need. Mexico!

This is not safe and it is not fair.

I am angered when I think about all of the people that the Republicans are leaving behind in this plan!

Why are we letting this happen to our abuelos? Our parents and grandparents? How can we be so heartless?

When I think about this plan, I think about all of the seniors who can't afford life saving prescription drugs.

I think about the senior who has glaucoma and prostate cancer and makes only $8,000 a year.

Like 750,000 other Hispanics, he won't get help paying for his prescription drugs, because he is lucky enough to have assets and owns a car.

According to Republicans, that is wealthy!

They will give tax breaks to millionaires, but under their plan, a man who makes $8,000 a year and is lucky enough to own a car, is too wealthy to get medicines that will ease his pain and save his life!

This is an outrage!

Under the Republican plan he would have to sell his car and pass an assets test to be poor enough to receive aide for low-income seniors.

When I think about this plan, I think about the senior who might make $10,000 a year.

That senior will pay one-fifth of his or her income to cover the Republican coverage gap.

One-fifth! This won't get him off the bus to Tijuana!

Like 63 percent of Americans, seniors in my district want and need the security of Medicare.

Under the Republican plan they may start in Medicare.

But after a couple of years, Medicare will only be a voucher program and where will seniors be?

In an HMO plan and still in a pharmacy in Tijuana buying medicine.

My constituents deserve better than the Republican plan!

They deserve more!

They deserve the Democratic plan that we have been fighting for for years!

A plan that cares about the health and safety of America's seniors!

A plan that actually works for America's seniors!

A plan that offers coverage to all seniors—even Hispanics!

It's time to take seniors off the bus to Tijuana!

Mr. MICHAUD. Mr. Speaker, tonight the House of Representatives considered a plan that would supposedly create a Medicare prescription drug benefit. While some touted the plan as an innovative approach, the fact is that when you look past the smoke and mirrors, it turns out to be a very bad deal for Maine's seniors. In fact, the House plan could make the current situation for seniors a lot worse: it will do nothing to control rising prescription costs, it will jeopardize the traditional Medicare fee-for-service plan that seniors enjoy right now, it has a large gap in coverage that will force seniors to pay thousands of dollars out of their pockets, and it may cause employers to drop their health coverage.

We all know that drug prices are spiraling out of control. Maine seniors are forced to take bus trips to Canada to buy affordable prescription drugs. Our best hope for getting affordable medicines to people is to lower prices—that is why Maine passed the innovative Maine Rx law, and that's why I introduced a national version of the bill called America Rx. Yet, the House legislation does nothing to control rising costs. In fact, this plan expressly prohibits the Secretary of Health and Human Services from ever negotiating with drug companies for better prices. Pharmaceutical companies are reaping huge profits while seniors are often forced to choose between medicine and food.

Furthermore, this plan doesn't guarantee a prescription benefit for seniors and it actually jeopardizes current Medicare coverage. The proposed benefit is entirely run by the private insurance industry and has no fallback provision of areas with no private plan. Without a fallback provision, there is no guarantee that private plans will be established in largely rural areas like Maine—so our seniors will be left in the cold. This has happened before with Medicare Plus Choice, and it is very likely to happen again, meaning that Maine's seniors would get nothing from this bill.

In addition, this bill also contains a ''premium assistance'' provision that aims to phase out traditional fee-for-service Medicare and replace it with a voucher program. This is just another step toward total privatization of Medicare and the elimination of the only plan available to seniors in areas such as Maine—the traditional Medicare plan. Forcing seniors into private plans, and making them give up Medicare, is not the right approach—but that's what this bill would do.

This bill also has a very large gap in coverage seniors would have to continue to pay a monthly premium, but would receive absolute no benefit fro drug costs between $2,000–$4,900. Having this kind of a gap in coverage is like telling people that their auto insurance doesn't cover accidents in June, July and August.

Finally, and perhaps worst of all, there is a provision in this bill that does not allow for retiree coverage to count toward the out-of-pocket spending cap. It has been estimated that the bill passed by the House would result in up to ⅓ of employers dropping their retiree coverage, the seniors who enjoy these plans would be forced into a Medicare plan with fewer benefits. The House should not pass a plan that forces seniors to lose what benefits they have.

For all these reasons, groups from AARP to the National Committee to Preserve Social Security and Medicare have sharply criticized this plan. I supported a number of alternative bills that would address the problems with this plan and vastly improve the benefit available to seniors. Unfortunately, the leadership of the House was more concerned about pushing any bill through as quickly as possible than with providing a quality benefit for seniors, and they weren't willing to fix the serious flaws in the bill that could hurt seniors. In fact, the House leadership refused to allow even one real amendment to the legislation.

I want to pass a real prescription drug benefit—but I would not vote for a plan that hurts Maine's seniors. I am disappointed with the legislation that was passed by the House, however the fight for a real Medicare benefit is not over. It is my hope that this legislation will be improved in the upcoming conference with the Senate. I will continue to fight to make sure that all Maine seniors receive an affordable and real Medicare prescription benefit.

Mr. LANGEVIN. Mr. Speaker, I rise in opposition to H.R. 1, the Medicare Prescription Drug & Modernization Act. Like many of my colleagues, I held sincere hope that the 108th Congress would overcome the inaction that has plagued this issue, at the expense of America's senior citizens, for many years. I am extremely disappointed that the bill before the House this week not only fails to offer a structurally sound prescription drug benefit for Medicare beneficiaries, but also contains provisions that threatens the stability of the program that has provided health benefits for millions of elderly people and younger adults with disabilities for the past 38 years.

In particular, I want to call attention to the fact that this bill does nothing to address the rapidly rising costs of prescription drugs. It not only fails to address this crisis, it contains a ''noninterference'' clause prohibiting the agents of the Department of Health & Human Services from using the bulk purchasing power of Medicare beneficiaries to negotiate for lower prices for senior citizens. Without taking measures to curb the escalating prices of the medications our seniors need to stay alive, the benefit is rendered meaningless. Seniors will pay more out of pocket in 2007 with the prescription drug benefit than they are paying in 2003 without it.

I urge my colleagues to pay careful attention to the details of the Medicare Prescription Drug & Modernization Act and to think critically about the effect—or lack thereof—it will have on the seniors in their districts.

Mr. ISRAEL. Mr. Speaker, I am proud to be a Democratic Member of this body. I have always been proud to be a Democrat. And always will be.

But I came to Congress 2½ years ago with a promise to my constituents that I would work hard to break through partisan gridlock. I promised that when I agreed with the Republicans I would vote with them; and when I disagreed I would vote against them. But that I would always work to develop consensus and move our country forward.

That is what brings me here today, Mr. Speaker.

In those 2½ years, I have focused on a health care crisis for seniors on Long Island. We used to have 12 Medicare HMOs in my communities. Now we have two

left. Eighty-five thousand seniors have been tossed out of their Medicare HMOs. One out of five is skipping their medication because they can't afford them.

And in those 2½ years, I have listened to Republicans blame Democrats for this crisis; Democrats blame Republicans; the House blame the Senate; the Senate blame the House; Congress blame the White House; the White House blame Congress; and everyone blame the insurance companies.

There is plenty of blame to go around. But all the blame in the world isn't going to help a single senior citizen get their prescription drugs at a more affordable price.

It's time to stop blaming. It's time to stop finger pointing. It's time for conservatives to stop railing against a $400 billion prescription drug plan because it's too liberal. It's time for liberals to stop railing against a $400 billion prescription drug plan because it's too conservative. It's time for everyone to stop rejecting the imperfect because we can't get the perfect. It's time to move this process forward.

Mr. Speaker, I believe the Democrats are right. It will take at least $800 billion to provide America's seniors with a truly comprehensive, voluntary prescription drug plan.

Is an $800 billion prescription drugs program better than a $400 billion program that's before us today? Of course. $400 billion is only half as good as $800 billion . . . but it is $400 billion better than nothing. And nothing is exactly what we will leave our seniors if we reject this proposal today.

To reject the largest expansion of Medicare in its 38-year history because it's $400 billion instead of $800 billion just doesn't make sense to me.

Mr. Speaker, only a short time ago, President Bush argued for a $190 billion prescription drug plan. My side of the aisle proposed an $800 billion plan. Some say we have ended up at a $400 billion plan.

I disagree. I think we are beginning with a $400 billion plan. It is the largest expansion of Medicare in its 38-year history. It is, in my view, a down payment. An investment.

Is this plan flawed? I believe it is. I believe the Senate plan, supported by TED KENNEDY, is much better. But we can't get near that plan unless we go to a House-Senate conference. And we can't go to a House-Senate conference unless we pass this bill today.

Yesterday at the White House, I listened carefully to President Bush. He said clearly we must move this process forward and pledged to work on a bipartisan basis to develop a final bill that represents consensus.

But there's no hope for consensus, no hope for a penny of prescription drug spending, if we slam the brakes on the process today by killing this bill today.

Mr. Speaker, of particular importance to me and the constituents I represent is that this bill contains the Greenwood-Israel-Fossella amendment, which ends the economic discrimination in federal reimbursement formulas to suburban Medicare HMOs that have forced 85,000 of my constituents out of their prescription drug plans.

Those seniors are watching us today. They are tired of blame, tired of gridlock, tired of excuses. They don't care whether it's a Democratic solution or a Republican solution, as long as it's a good solution.

This is not a perfect solution. But it is a good start. It is the largest expansion of Medicare in its 38-year history. It ends the price discrimination on Long Island and other suburbs around the nation.

Mr. Speaker, let me close by repeating this: $400 billion is only half as good as $800 billion . . . but it is $400 billion better than nothing. And nothing is exactly what we will leave our seniors if we reject this proposal today. In the spirit of advancing the process, I will support this bill. I reserve the right, however, to vote against a bill that emerges from Conference that does not address the significant flaws in the legislation before us tonight.

Mr. EVANS. Mr. Speaker, this Republican Medicare bill falls well short of what our country's retirees deserve. And I believe, that if this Congress and this President had not squandered the budget surplus we could afford to give our seniors a benefit they deserve.

It is well past time to assist with our seniors prescription drug costs. The Democratic substitute provides a reliable and affordable benefit to America's seniors. This voluntary prescription drug coverage costs only $25 a month with a $100 deductible and provides a $2000 stop-loss protection with no gaps in coverage. There are also special provisions to help the poorest seniors with either full payment or assistance on a sliding fee scale.

The Democratic substitute I support also allows the Secretary of Health and Human Services to wield the collective bargaining power of the 40 million Medicare beneficiaries to negotiate lower drug prices. And as the ranking member on the Veterans' Affairs Committee, I was proud to help craft a similar plan which has helped our nation's veterans lower their out of pocket drug costs.

As a member representing a rural district, I also want to highlight the rural health care provisions included in the Democratic substitute. These provisions are essential to create equity in the reimbursement system between urban and rural hospital. They allow fair payments to hospitals that have a disproportionate share of low-income patients, increases payments to rural home health providers without requiring a co-pay, and adjusts low-volume payments for small hospitals. It also takes into account the physician shortage crisis in rural areas by finally correcting the huge disparity between urban rural hospitals, that drives providers from our small towns.

All of these reasons make the Democratic alternative to H.R. 1 the right answer to the spiraling costs for prescription drugs for seniors. Medicare works for America's seniors but, I oppose the GOP's efforts to privatize this system and provide a second-rate prescription drug benefit. I proudly support the Democratic substitute and I urge my colleagues to vote down H.R. 1 and vote Yes on the substitute.

Mr. CUMMINGS. Mr. Speaker, I rise today to speak against the inadequate Medicare prescription drug bill being considered today, H.R. 2473 and in support of the Rangel/Dingell Substitute.

With over 40 million elderly and disabled persons covered under the 38-year-old Medicare entitlement, Congress' chief objective should be to ensure that these Americans have access to quality health care coverage. However, today we consider legislation that will do more harm than good because it is the first step in privatizing the Medicare program and as former Speaker Gingrich predicted, causing it to ''wither on the vine''. Passage of this legislation will cause many of our seniors to wither right along with the Medicare program—which will no longer be seen as the social compact with our seniors that this nation embraces.

Medicare is the nation's second largest social welfare program. As an entitlement program, it is imperative to realize that with the implementation of H.R. 2473, fee-for-service Medicare payments would naturally increase. This will result in many seniors facing the horrible prospect of being unable to afford the increasing payments. I think many of my colleagues would agree that this is a very troubling proposition and a totally unnecessary result.

Additionally, with the establishment of the Voluntary Prescription Drug Benefit Program, seniors again would lose because of the lack of negotiated prices for the prescription drugs. Also, although federal subsidies would be provided to encourage participation, the bill would increase the annual out-of-pocket threshold for many beneficiaries. Once again a pseudo-solution of adding a prescription drug benefit while increasing the cost for persons who need the benefit but will not be able to afford its costs.

Furthermore, the use of health maintenance organizations (HMOs) and other private organizations to obtain prescription drugs would deter many seniors from getting the benefit. As Rep. Charles B. Rangel, Ranking Democrat on the Committee on Ways and Means stated, ''to get prescription drug coverage, seniors would have to go to an HMO by another name. Then, all the choices would belong to the private insurance provider—which drugs are covered, which pharmacies you can choose, who your doctor is, etc.'' Mr. Speaker, this bill is an empty pillbox—it is a paltry solution to the problem of providing adequate prescription drug coverage to our seniors; rather, it is creating an inadequate system—based on a provider concept that does not currently exist and will not likely work in practice.

A better alternative to H.R. 2473 is The Medicare RX Drug Benefit an Discount Act (H.R. 1199) offered by my friend CHARLIE RANGEL of New York. This prescription drug plan would guarantee that every Medicare beneficiary, no matter where they live, could have a benefit with a $25 monthly premium, $100 annual deductible, 20 percent co-insurance and $2000 out-of-pocket limit. The bill would also:

Lower prescription drug cost for all Americans, regardless of whether they are covered by Medicare;

Give all Medicare beneficiaries the option of a reasonably priced guaranteed prescription benefit under Medicare;

Ensure that senior citizens and people with disabilities receive coverage for the drug that their doctor prescribes; and

Provide additional assistance for low-income beneficiaries such that many seniors would pay nothing for their prescription drugs.

Unlike the proposal put forth by the Bush Administration and endorsed and worsened by the House GOP Leadership, H.R. 1199 would not require seniors to join an HMO or similar private plan in order to get a prescription drug benefit. In fact, Medicare beneficiaries would be guaranteed a prescription drug benefit rather than offered a marginal, voluntary plan under H.R. 2473. This plan would ensure that we keep our social compact with our seniors. The Republic plan fails to do that.

Since its inception 1965, Medicare has provided important protection for millions of aged and disabled persons. H.R. 2473 would be a detriment to improving and securing this system. I lend my voice in opposition and urge my colleagues to vote against H.R. 4273 and to support H.R. 1199.

Ms. WATERS. Mr. Speaker, I rise to oppose this Medicare privatization plan, which is masquerading as a prescription drug bill.

This bill would force seniors who want prescription drug coverage to get it from private insurance companies. It provides no guarantee that insurance plans will be available, and when they are, premiums and benefits will vary widely. The bill also provides no coverage when a senior's prescription drug costs are between $2,000 and $4,900 per year. This huge coverage gap affects 47 percent of Medicare beneficiaries.

This bill is also a give-away to pharmaceutical companies, as it prohibits the Secretary of Health and Human Services from negotiating lower drug prices. The primary beneficiaries of this bill are not the beneficiaries of Medicare. They are the wealthy special interests in the pharmaceutical industry and the insurance industry that give campaign contributions to Republicans.

However, the most outrageous aspect of this bill is what it does to traditional Medicare. The bill would increase seniors' cost for visits to the doctor's office by raising the Medicare Part B deductible and indexing it for inflation. This could cost American seniors an estimated $8 billion. While this may seem like a tiny fraction of the Republicans' $350 billion tax-cut-for-the-rich, it is a huge expense for senior citizens, many of whom live on limited incomes.

This bill also divides Medicare into 10 or more regional plans in 2006 and then converts the entire Medicare program into a voucher program depending upon private insurance companies in 2010. If the Republicans really want to privatize Medicare, they should be honest with the American people and call this plan what it is, the Medicare Privatization Act.

The Democrats alternative prescription drug plan on the other hand provides prescription drug coverage under Medicare with guaranteed and affordable premiums and benefits for all American seniors and no gaps in coverage. It is time for Congress to make prescription drugs available to all seniors who need them.

I urge my colleagues to oppose the Republican Medicare Privatization Act and support the Democratic alternative.

Mr. ISTOOK. Mr. Speaker, this bill will hasten the day when Medicare will go bankrupt, and it also threatens to unravel our children's future.

Medicare is already on shaky financial legs, and this will add enormous extra expenses that will make it worse. Do we expect our children to pay a lifetime of higher taxes, and still find there's nothing left for them when they retire? That is what we face.

I would like to add prescription drug benefits, but it's wrong to promise something we cannot pay for.

I want to preserve what's good about Medicare, not destroy it by making extravagant promises for political gain.

The enormous extra spending under this bill will be far more than projected. Because today's Medicare is a huge price control system, many doctors already refuse to see Medicare patients. In just a few years this will make it worse, including price controls that will destroy the incentives for companies to create new medicines.

What should we be doing?

Since 76 percent of seniors already have drug coverage, we could focus on helping those who don't. But this bill undoes the coverage for those 76 percent, and puts them in a confusing new medical experiment.

We should be stabilizing Medicare, so it can keep the promises already made, not making new promises that we don't have the money to keep.

We should address the reasons why drug prices and healthcare costs are so high. By banning re-imported drugs, we're forcing Americans to subsidize far-lower drug prices in other countries. We should change our policies so Americans only pay the lower world price, not a higher price.

We should end the 130,000 pages of federal regulations that have driven the costs of medicine and healthcare through the roof. On average, for every hour they spend with a patient, doctors and nurses spend another half-hour to a full hour doing government paperwork.

We should stress personal responsibility in healthcare, just as we did in welfare reform, so government resources are focused on those who cannot care for themselves, not on those who can.

Bit-by-bit, Congress is undoing the principles of welfare reform, and undercutting basic American principles in the process. Both political parties are making extravagant promises today, trying to outbid each other to win votes. Unfortunately, they are bidding with taxpayers' own money, and our children's hopes will be crushed by the bills they inherit.

Mr. PORTMAN. Mr. Speaker, I rise to speak in supper of provisions in H.R. 1, The Medicare Prescription Drug and Modernization Act, that are designed to address the special pharmacy needs of beneficiaries residing in nursing homes.

Nursing home residents are not in a position to fill prescriptions like everyone else. They cannot simply walk into a pharmacy and have their prescription filled. Many nursing home residents, because of their physical or mental condition, are not able to take their prescription drugs on their own, especially if they have to take multiple medications throughout the day. Their unique circumstances require specialized pharmacy care that retail and mail order pharmacies do not provide. Long-term care pharmacies meet these special needs. They contract with nursing homes to provide specialized packaging, 24-hour delivery, infusion therapy services, geriatric-specific formularies, clinical consultation and other services that are critical to a nursing home. Importantly, long-term pharmacies play a critical role in preventing medication errors that add to the cost of care and suffering of Medicare patients. In fact, one study estimates $3.6 billion in medication errors have been avoided as a result of long term pharmacy care. I believe it makes sense to preserve specialty pharmacies' ability to perform these vital services for nursing home residents, and I want to point out how H.R. 1 does this.

First, the bill requires the Secretary of Health and Human Services to review the current standards of practice for pharmacy services provide to patients in nursing facilities. Prior to implementation of the prescription drug benefit, the Secretary will submit its findings to Congress on how long-term pharmacy services will be available to nursing home residents, including appropriate reimbursement levels for the specialty pharmacies that currently serve these nursing home residents. The Secretary's report is to include a detailed description of its plans to implement the provisions of this legislation in a manner consistent with state and federal laws designed to protect the safety and quality of care of nursing facility patients.

Second, H.R. 1 directs plan sponsors to implement medication therapy management programs as a tool to reduce medication errors and improve patient outcomes. Long-term care pharmacies currently employ such initiatives to meet the complex medication needs of nursing facility patients, and the bill appropriately allows plan sponsors' programs to distinguish between services provided in ambulatory and institutional settings.

Finally, the bill includes provisions to ensure that beneficiaries are guaranteed access to pharmacy services, including emergency services. These provisions are vitally important to maintain the high standard of care for all beneficiaries, but particularly for patients in nursing facilities, who receive specialized pharmacy services 25 hours-a-day, seven days-a-week, through networks of long-term care pharmacies that contract with nursing facilities to meet their patients' needs.

Mr. Speaker, I believe these long-term pharmacy provisions take a significant step toward ensuring that our nation's most frail and elderly citizens will have affordable, appropriate prescription drugs and delivery services.

Mr. BASS. Mr. Speaker, as a member of the Energy and Commerce Committee, I am extremely pleased to have had the opportunity to develop a strong Medicare modernization package that will significantly improve this critical government program.

The seniors of New Hampshire have long clamored for a prescription drug benefit under Medicare, as is the case in the rest of the nation. I am pleased to represent those same seniors today as we pass this bill and take one giant step closer toward our goal of creating a new and voluntary prescription drug benefit that makes lifesaving medications more accessible.

This benefit is the product of years of research, study, testimony, and compromise. I have no doubt whatsoever that each of us might wish for a slightly different version of this bill. We represent different regions with different demographics.

And, I am sure we all wish lifesaving drugs were more affordable for our families, friends, and constituents. The goal is formulating a fiscally responsible plan that will remain solvent in years to come, is easily accessible, and increasingly beneficial to seniors of all regions and means, was a daunting one.

Yet, the bill makes a number of Medicare improvements for care providers in New Hampshire. This proposal represents one of the most generous rural packages ever contemplated by the House. Notably, after several years of efforts on the part of the rural medical community, uniform standards for Medicare reimbursements will be established for rural and small urban facilities.

Beginning October 1, Medicare reimbursements to rural areas would finally mirror those for large urban ones. Having lamented for a

number of years over the inequity of this provision within the Medicare reimbursement system, I am particularly pleased that this is being addressed in the bill.

A drug benefit for seniors and a rejuvenation of the Medicare system are essential to seniors and their caretakers. The delivery of medical care has changed enormously since this program was first conceived, and the program ought to be modernized to reflect the increases in medical technology and the utilization of a wide range of care options.

As I have noted many times, no plan can be as all-encompassing and immediately satisfying as we might prefer. However, this bill puts the framework in place for a system that can be adjusted and improved upon over time and will directly and immediately help the population most in need.

I applaud all Members of the Energy and Commerce Committee and the Members of the Ways and Means Committee for the joint work on this essential legislation. It is my hope that upon completion of our floor vote today, we will see this measure moved forward immediately to conference with the Senate.

Mr. KNOLLENBERG. Mr. Speaker, today we have an opportunity to provide our seniors with a new prescription drug benefit and improved access to health care. It is a long overdue step in updating and improving Medicare.

Today's legislation will provide help for those who need it most. Our 6.5 million low-income seniors will receive a fully covered premium and a cost sharing benefit when their drug benefit switches from Medicaid to Medicare, paying no more than $2 per generic prescription, and no more than $5 for name brand drugs. This will also save states about $6.8 billion a year in Medicaid costs.

It is imperative that Medicare advance with technology. Prescription drugs are an increasingly important part of modern medicine, helping to relieve pain, cure disease, and enhance the lives of millions of Americans. Adding a drug benefit and updating how existing benefits are provided will be a very significant accomplishment.

Mr. Speaker, I encourage my colleagues to vote for this legislation that helps our seniors by providing a prescription drug benefit that they deserve.

Mr. MOORE. Mr. Speaker, I rise today to express my opposition to this legislation and my support for the Blue Dog substitute, offered by Rep. THOMPSON, which we have not been allowed to debate on the House floor today, despite support on both sides of the Capitol.

We in Congress have been talking for years now about the necessity of adding a prescription drug benefit to Medicare. We know, as seniors know, that this talk has been cheap and it is imperative that a compromise be reached this year. The Senate has been proceeding in a bipartisan way toward a compromise that adds a substantial, but not perfect, benefit to Medicare and protects the long-term integrity of this social insurance program.

Instead of following the Senate's lead and working toward a compromise that will improve Medicare, a wildly popular and successful program, the House Republican leadership has chosen instead of add provisions to this legislation that attack the foundation of the Medicare program. The bill does not include a federal fallback if private plans choose not to offer a benefit. The experience that my constituents have had with Medicare+Choice show that private health care plans are at best an unstable partner for Medicare, and financial analysts have consistently publicly questioned whether ''drug only'' plans will ever be offered. For these reasons, it is absolutely vital that Medicare provide a viable and guaranteed fallback for all Medicare beneficiaries.

Additionally, H.R. 1 would transform Medicare, beginning in 2010, from a defined-benefit program to a defined-contribution program. This provision would gradually shift enormous costs onto people when they are sick and most in need of care, and destroy the fabric of this program that has served seniors well for nearly 50 years.

The Senate has crafted legislation that has broad support among Senators across the ideological spectrum. This legislation has won the support of both President Bush and Senator TED KENNEDY. Together with Representative THOMPSON and the Blue Dog Caucus, I am supporting legislation that uses the framework of the Senate compromise and improves on it, making it a much stronger bill. The Thompson plan includes a provision phasing in employer contributions to they will count toward the out-of-pocket limit for catastrophic coverage, thus giving employers an incentive to keep offering retiree benefits. The substitute guarantees a Medicare fall-back plan for all areas that do not have two private plans available. It also gives relief to state Medicaid plans by making Medicare the primary payer for all individuals eligible for Medicare and Medicaid. Finally, the Blue Dog substitute includes language that will reduce the high cost of prescription drugs by allowing Americans to reimport drugs from Canada and speeding approval of generic drugs.

The House bill falls short on several other fronts as well. It ignores the needs of community and teaching hospitals, meaning that hospitals in my district stand to lose over $11 million in denied inflation updates. Kansas teaching hospitals, like KU Med, would additionally lose out to the tune of $3.9 million in 2003 and $21 million over five years due to the Federal Government's failure to help pay for the excess costs of medical education. The Thompson substitute provides an adequate inflation update for all hospitals. Finally, H.R. 1 would cut $16 billion over 10 years from oncology services. Cancer patients all over the country will have to pay for provisions in this bill that sharply cut funding for cancer-fighting drugs and allow Medicare to continue to underpay for costs associated with providing chemotherapy services.

I cannot support the Democratic substitute because I believe that it is simply too expensive. I voted against the most recent tax cut because I believe that it is irresponsible for Congress to run up bills for our children to pay, and the Democratic substitute, although a much more robust benefit for our seniors, is simply more than our country can afford at this time. The Senate bill and the Blue Dog substitute both hew to the budget agreed to by the House and Senate. Neither bill is perfect, but I believe that the Thompson substitute builds a strong foundation for a prescription drug benefit on which we can build in future years.

Mr. CAPUANO. Mr. Speaker, today we have the opportunity to provide our seniors with a real prescription drug benefit, but instead of giving seniors the plan they deserve, we are taking steps to dismantle a program that older Americans have known and trusted for 38 years.

The Republican plan before us today fails to offer the types of guarantees that our seniors need and deserve. There is no defined benefit and no standard premium. So when my seniors ask now much their premiums will be or how much their drugs will cost, I cannot answer them. This is unacceptable.

This bill allows private insurance companies to decide premiums, prescription drug coverage benefits and even where coverage will be offered. This proposal threatens to dismantle Medicare and replace it with private health insurance coverage for all seniors. This is precisely the problem many seniors face—they cannot afford private insurance, and depend on Medicare.

This bill also provides additional funding for rural hospitals, but not urban teaching hospitals. This is a serious oversight. Urban teaching hospitals are facing incredible budget shortfalls. They play a critical role in training tomorrow's physicians, and their needs must also be addressed. If the Federal Government is going to offer additional funding to some hospitals, it must offer additional funding to urban teaching hospitals.

The Federal Government has a responsibility to ensure that Americans who contribute to the Medicare program during their working years will have access to dependable, equitable, and affordable health coverage. The Democratic substitute does just that—it lowers drug prices, guarantees coverage and enables seniors to get their medicines at the pharmacy of their choice. The Rangel/Dingell substitute addresses my concerns more effectively and I will strongly support it.

Mr. LEACH. Mr. Speaker, seldom has there been a more important bill for the State of Iowa.

On the one hand, this legislation provides for greater equity in Medicare reimbursement which will bring millions of additional dollars to the state and help prevent an exodus of healthcare providers from rural counties.

In addition, the brunt of the bill is about providing voluntary prescription drug coverage to Medicare eligible individuals. There is a conservative critique that the program is far too expensive, and a liberal critique that it is not generous enough. Both philosophical perspectives have a degree of validity, but the big picture is that Congress is moving in a direction of providing health security for millions of citizens. Low income individuals will, for the most part, be provided full comprehensive prescription drug coverage. Higher income citizens on a sliding scale will be provided partial coverage and all citizens will be provided coverage for catastrophic expenses.

There will be a cost to society in providing these benefits but the benefits far outweigh the costs. There may be better approaches that can be envisioned now or developed later, but this is the only framework approach that has a chance of receiving majority support in both bodies without a Presidential veto. It may not be enough and it may be too deferred in implementation but it nevertheless marks an important first step to meeting the most challenging need of many senior citizens.

Ms. DEGETTE. Mr. Speaker, I want to highlight a piece of the Dingell/Rangel substitute that pertains to Disproportionate Share Hospitals.

This was an amendment I offered in the Energy & Commerce Committee and I understand that since our mark-up the DSH allocation has been increased and I want to commend this action. I know there is real bipartisan support on this issue and I want to just reiterate how important it is that we get funding to our DSH hospitals right away.

The provision in the substitute would give DSH hospitals a large portion of the funding that has been cut in the past year. It would expend a billion dollars in FY '03 and then adjust payments in future years to ensure that our vital DSH hospitals do not go bankrupt.

The reason it is so important that this money is available next year is that our DSH hospitals have already suffered a cut of a billion dollars in the past year and now are in such bad shape financially, if we help them in dribs and drabs then many of them won't be around ten years from now.

There are public hospitals who are currently planning to make cuts of 25 percent next year in order to try to stay afloat.

Mr. Speaker, our public hospitals cannot afford these cuts. We are in real danger of losing numerous DSH hospitals over the next few years if we do not assist them right now.

This provision also helps the low-DSH hospitals which are the most strapped of all. Eighteen states have low DSH hospitals due to historical expenditures that were basically frozen in place at a certain point.

These low-DSH states have been struggling for years with their Medicaid payments and they are currently held to only 1 percent of their Medicaid expenditures. My amendment, which accomplishes the same thing that a bill Rep. HEATHER WILSON introduced, would raise this to 3 percent which would help these states considerably.

While low-DSH states have been dealing with this situation for years, recently it has gotten much worse. The pressure on these hospitals has increased due to numerous factors such as increasing numbers of the uninsured, increasing numbers of Medicaid patients, the extreme situation so many states are in in terms of budget crises.

The fact of the matter is that DSH hospitals need help and need help now. They can't wait and we need to rectify this situation while the DSH hospitals are still around to help our most vulnerable citizens.

Mr. DELAURO. Mr. Speaker, in my 13 years in Congress, this House has sometimes risen to the occasion on matters of great national importance. My very first vote on the first Gulf War followed days of debate in which Members stated their heartfelt views on the prospect of war. After September 11th, we came together—Democrats and Republicans—to bind the nation's wounds and provide for the national security of the nation's victims of that terrorist act.

I wish I could say that this is one of those eoccsions—I wish I could say that, as we consider the very future of Medicare, we could rise above partisan politics and ideological viewpoint and do the right thing by our senior citizens. Medicare is one of the most important and successful government programs ever enacted, a program that has provided quality health care and a measure of economic security to hundreds of millions of senior citizens over the past four decades. Together, Medicare and Social Security represent the twin pillars of a social safety net and constitute what is in effect a social contract between the generations—that if you work hard all your life you may look forward to a dignified retirement and economic security in your old age.

I understand that we bear the responsibility of meeting the newest challenges that face our seniors—of finding new ways to care for our aging population and that changes to Medicare need to be made. Central to that process is dealing with the cost of prescription drugs and helping seniors afford them.

Unfortunately, the legislation before the House this week fails on both counts. It does not deliver an acceptable or adequate prescription drug benefit and it will not hold down the cost of drugs.

What it does do is open the door to privatization of Medicare—in other words, a return to the way things were before, when 1 out of every 3 seniors lived in poverty, largely due to the cost of medical expenses. Today, thanks to Medicare, that rate is closer to 1 in 10.

This bill sets in motion the privatization of Medicare by converting the program into a voucher system—essentially turning it over to the HMOs, the very organizations that have dropped 52 percent of the Medicare enrollees in my state over the last four years.

And it does nothing to contain costs. It prohibits the Secretary of Health and Human Services from even engaging in negotiations with the drug companies to lower prices. As a result, many seniors will pay more than they do now and their premiums will rise as the cost of drugs rises.

But the most inexplicable aspect of this bill is the huge gap in coverage. Once a senior receives drug benefits totaling $2,000, he or she is cut off until her bills total $4,900, necessitating that they pay $2,900 out of her own pocket—at the same time that they pay premiums for this supposed drug benefit.

It makes no sense. Throughout my time in Congress, the single most common concern I have heard from seniors at the local Stop N' Shop every weekend is how expensive their prescription drug bills are. Seniors know they are being taken advantage of. They know they can get drugs cheaper in Canada and overseas.

And I assure you when they find out we are doing nothing to hold down the excessive profiteering of the pharmaceutical companies, they are going to be angry. When seniors find out that their coverage essentially stops during mid-summer while they still have to pay premiums, they are not only going to be confused, they are going to feel utterly betrayed.

Mr. Speaker, we must provide a meaningful drug plan with guaranteed, defined benefits—with no gaps and no doughnut holes. We should act to contain costs by giving the Secretary of HHS the authority to negotiate lower prices so that seniors will not have to pay more than seniors in other countries for the same drug.

And perhaps most importantly we should honor our social contract with America's seniors by not privatizing Medicare and subjecting seniors to the uncertainties of the private health care market. We should not be penalizing seniors who live in rural communities, where pharmacies and private plans are scarce at best. We should be giving them a plan fully contained within the Medicare system, where seniors will not be forced to shop around for a plan only to be unceremoniously dropped soon thereafter. Giving them a plan that seniors have come to rely on and feel safe with is what we should be doing. That is real economic security. Medicare—the same plan my 89 year-old mother relies on today.

This debate is as important and historic as any I have been a part of in this body. If we allow this bill to become law, we are essentially tearing that social contract up—a contract my friend from Michigan, Mr. DINGELL, fought to pass 38 years ago. And by doing so, we would be saying that guaranteed health care for our seniors is no longer an obligation or responsibility of this government.

I did not come to Congress to preside over the dismantling of Medicare. That contract must be honored. I urge my colleagues to support a plan that does that.

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act. I want to thank Congresswoman LYNN WOOLSEY for her hard work in bringing Democratic women together to speak against the Republican's shameful Prescription Drug bill.

As a freshman Member of Congress, I came here with a tremendous sense of optimism. By nature, I am an eternal optimist. But I am no fool, and the American people shouldn't be fooled either. Unfortunately, that is exactly what the Republicans are trying to do with their sham Prescription drug bill.

If you believe the Republican bill solves the prescription drug crisis facing our seniors . . . If you think that seniors will get the medications they need, at a price they can afford . . . If you believe private insurance companies—the same people who brought you HMOs—will provide better coverage for seniors than a reformed Medicare system . . . or if you think you can get all the drugs your doctor prescribed, including the most expensive, at your local pharmacy. . . . Then you should be listening to that old country song by George Strait called ''Ocean Front Property.'' It goes something like this:

I've got some ocean front property in Arizona from my front porch you can see the sea.

I've got some ocean front property in Arizona and if you'll buy that I'll throw the Golden Gate in free.

Republicans are just like scam artists trying to sell you an ocean front property in the desert. But now they are trying to sell you a phony prescription drug package. We must not fall for it, especially when this is not what seniors want.

I say to my Republican colleagues, it is time to stop this heinous scam on seniors! It is time to show the greatest generation in our country the respect they deserve. After all, they are the people who served us in times of war, got us through the Great Depression, raised their children and made countless contributions to this country.

Worst of all, the Republican bill ignores the reality of older women, the face of Medicare. Women constitute 58 percent of the Medicare population at 65 and 71 percent at the age of 85. Since women normally outlive their male counterparts and many women spend time out of the workforce, caring for their children and sometimes, their own parents, Medicare beneficiaries are disproportionately female.

We need to make sure that every prescription is covered without a gap. Seniors, particularly women, must retain their right to see their

doctor of choice. We must empower seniors to make the right choices, not insurance companies. This is exactly what the democratic plan does and exactly what seniors want. In fact, according to a survey conducted by AARP: 4 out of 5 seniors don't want the GOP proposal.

Today, Mr. Speaker, I urge my colleagues not to support H.R. 1. Let's tell the Republicans don't try to sell seniors something they don't want.

Mr. JANKLOW. Mr. Speaker, I would like to submit the following letter into the CONGRESSIONAL RECORD.

BUSINESS FOR AFFORDABLE MEDICINE,
Washington, DC, June 24, 2003.

Hon. DENNIS HASTERT,
Speaker, U.S. House of Representatives, Washington, DC.

DEAR SPEAKER HASTERT: We urge you to pass legislation as part of Medicare reform that will improve the Drug Price Competition and Patent Term Restoration Act, and the patent listing requirements under the Federal Food Drug, and Cosmetic Act (FFDCA).

States spend billions of dollars annually and provide prescription medicine to residents, state employees, and retirees. Tax payers are forced to pay hundreds of millions of dollars in excess costs for the medicine because of loopholes in the Hatch-Waxman Act that restrict timely access to lower-cost generic pharmaceuticals. As a result, BAM members, including states, companies, and labor groups, support changes to the Hatch-Waxman Act that will provide greater pharmaceutical competition and more timely access to generic.

Bipartisan legislation passed by the Senate last week will provide all purchasers with greater access to generics, and will produce hundreds of millions of dollars in savings for federal and state programs. We urge the House to adopt similar legislation as part of the effort by Congress to add a prescription drug benefit to Medicare, and urge you to resist changes or amendments that would weaken the most important cost-savings provisions in the Senate bill.

Specifically, BAM supports the proposed limit of one 30-month stay against FDA approval of generic products, as well as provisions to prevent the use of ''late-listed'' patents—those filed after generic applications are submitted—to obtain additional stays. Litigation under the Hatch-Waxman Act is increasingly tied to patents that have been listed after the filing of generic applications, resulting in the need for legislation to restrict the use of 30-month stays to only those patents listed in the Orange Book prior to the filing of related generic applications. We also support changes to provisions in the law that allow drug manufacturers to intentionally delay litigation on certain drug patents until the end of any 30-month stay.

In addition we are concerned that consumers, taxpayers and institutional purchasers have no standing under current law to challenge abusive listing. As a result, all purchasers have been forced at times to pay millions of dollars more than necessary for products that should have faced more timely competition from generics. We support efforts to ensure generic manufacturers will be provided with the most effective avenues possible for relief from unlawful listings.

BAM is committed to working with all members of Congress to restore balance to the Hatch-Waxman Act and improve pharmaceutical competition. We look forward to assisting your efforts.

Sincerely,

GOVERNOR M.J. ''MIKE'' FOSTER, JR.,
Louisiana,
GOVERNOR BOB WISE,
West Virginia.
GOVERNOR BRAD HENRY,
Oklahoma.
GOVERNOR BOB HOLDEN,
Missouri.
GOVERNOR RONNIE MUSGROVE,
Mississippi.
GOVERNOR THOMAS VILSACK,
Iowa.

Mr. ROGERS of Alabama. Mr. Speaker, one of the promises I made when I came to Washington was to improve the lives of East Alabama seniors. Unlike retirees in our country's metropolitan areas, the seniors of the Third District face far greater challenges.

For starters, most Third District seniors lives in rural areas with few choices in health care providers. This undoubtedly means higher health costs and fewer costs when it comes to doctors, and higher out-of-pocket expenses for covering the same level of basic medical needs.

Part of the problem, Mr. Speaker, is Medicare does not fairly and adequately reimburse doctors for their services. This is not fair, especially when retirees just across the Georgia border have far better access to doctors who are reimbursed by Medicare at higher rates. Seniors should not be penalized just because they live in rural areas.

But assuming we fix the reimbursement problem, this still leaves Medicare as a program designed for the 1960s, yet providing care in 2003. That's why I'm pleased to be in the House today to offer my full support for adding a prescription drug benefit under Medicare.

Earlier this year, Speaker HASTERT appointed me to his Prescription Drug Action Team to help craft a prescription drug benefit for Medicare. I've taken this responsibility around the Third District to listen to seniors describe what they think this benefit should do, and how it should be designed.

First and foremost, we must reduce the costs of prescription drugs. Modern medicine relies on these life-saving drugs more than ever, and doctors shown no signs of slowing the expected growth in prescriptions. But with Alabama seniors now paying an average of $1,200 per year for prescriptions, these costs are getting out of hand.

Consider seniors on fixed incomes, Mr. Speaker. These Alabamians, already strapped with highly monthly bills, now face the costs of prescriptions rising beyond their means. We've already seen prescription drugs double or even triple in cost over the years. What will these seniors do when these drugs are priced out of reach? Will they be faced with filling their medicine cabinet or their pantry?

Mr. Speaker, this simply cannot continue. The U.S. House of Representatives has drafted a bill, the Medicare Prescription Drug Modernization Act of 2003, which includes a prescription drug benefit for seniors in both the traditional fee-for-service and in the new integrated health plans. The bill is not limited to adding prescription drug coverage for our state's seniors, but also includes much-needed modernizations to Medicare and improvements for health care providers, such as an increase in Medicare payments to doctors to ensure that seniors continue to have access to physician services. Most importantly, the bill includes improvements and increased funding for rural hospitals in the Third District.

This is hardly a perfect bill, but it is a good bill. The legislation helps Alabama's seniors receive better health care under Medicare and provides immediate relief from high prescription drug costs. President Bush supports it, and is ready to sign this bill should the House and Senate pass it.

Mr. Speaker, I'm proud to be in this House today and have the chance to improve the lives of Alabama's seniors. I will continue to work with my colleagues on both sides of the aisle, as well as those in the Senate, to help pass this important legislation now, and send it to the White House for President Bush to sign into law.

Mr. TAUZIN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). All time for general debate has expired.

GENERAL LEAVE

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 1.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. RANGEL

Mr. RANGEL. Mr. Chairman, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. RANGEL:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Prescription Drug and Modernization Act of 2003''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT

SEC. 101. VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION MEDICINE PROGRAM.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating section 1859 and part D as section 1858 and part E, respectively; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND DISABLED

''MEDICARE OUTPATIENT PRESCRIPTION MEDICINE BENEFIT

''SEC. 1859. Subject to the succeeding provisions of this part, the voluntary prescription medicine benefit program under this part provides the following:

''(1) PREMIUM.—The monthly premium is $25.

''(2) DEDUCTIBLE.—The annual deductible is $100.

''(3) COINSURANCE.—The coinsurance is 20 percent.

''(4) OUT-OF-POCKET LIMIT.—The annual limit on out-of-pocket spending on covered medicines is $2,000.

''NEGOTIATING FAIR PRICES WITH PHARMACEUTICAL MANUFACTURERS

''SEC. 1859A. (a) AUTHORITY TO NEGOTIATE PRICES WITH MANUFACTURERS.—The Secretary shall, consistent with the requirements of this part and the goals of providing quality care and containing costs under this part, negotiate contracts with manufacturers of covered outpatient prescription medicines that provide for the maximum prices that may be charged to individuals enrolled under this part by participating pharmacies for dispensing such medicines to such individuals.

''(b) PROMOTION OF BREAKTHROUGH MEDICINES.—In conducting negotiations with manufacturers under this part, the Secretary shall take into account the goal of promoting the development of breakthrough medicines (as defined in section 1859H(b)).

''CONTRACT AUTHORITY

''SEC. 1859B. (a) CONTRACT AUTHORITY.—

''(1) IN GENERAL.—The Secretary is responsible for the administration of this part and shall enter into contracts with appropriate pharmacy contractors on a national or regional basis to administer the benefits under this part.

''(2) PROCEDURES.—The Secretary shall establish procedures under which the Secretary—

''(A) accepts bids submitted by entities to serve as pharmacy contractors under this part in a region or on a national basis;

''(B) awards contracts to such contractors to administer benefits under this part to eligible beneficiaries in the region or on a national basis; and

''(C) provides for the termination (and nonrenewal) of a contract in the case of a contractor's failure to meet the requirements of the contract and this part.

''(3) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

''(4) TERMS AND CONDITIONS.—Such contracts shall have such terms and conditions as the Secretary shall specify and shall be for such terms (of at least 2 years, but not to exceed 5 years) as the Secretary shall specify consistent with this part.

''(5) USE OF PHARMACY CONTRACTORS IN PRICE NEGOTIATIONS.—Such contracts shall require the contractor involved to negotiate contracts with manufacturers that provide for maximum prices for covered outpatient prescription medicines that are lower than the maximum prices negotiated under section 1859A(a), if applicable. The price reductions shall be passed on to eligible beneficiaries and the Secretary shall hold the contractor accountable for meeting performance requirements with respect to price reductions and limiting price increases.

''(6) AREA FOR CONTRACTS.—

''(A) REGIONAL BASIS.—

''(i) IN GENERAL.—Except as provided in clause (ii) and subject to subparagraph (B), the contract entered into between the Secretary and a pharmacy contractor shall require the contractor to administer the benefits under this part in a region determined by the Secretary under subparagraph (B) or on a national basis.

''(ii) PARTIAL REGIONAL BASIS.—

''(I) IN GENERAL.—If determined appropriate by the Secretary, the Secretary may permit the benefits to be administered in a partial region determined appropriate by the Secretary.

''(II) REQUIREMENTS.—If the Secretary permits administration pursuant to subclause (I), the Secretary shall ensure that the partial region in which administration is effected is no smaller than a State and is at least the size of the commercial service area of the contractor for that area.

''(B) DETERMINATION.—

''(i) IN GENERAL.—In determining regions for contracts under this part, the Secretary shall—

''(I) take into account the number of individuals enrolled under this part in an area in order to encourage participation by pharmacy contractors; and

''(II) ensure that there are at least 10 different regions in the United States.

''(ii) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of administrative areas under this paragraph shall not be subject to administrative or judicial review.

''(7) SUBMISSION OF BIDS.—

''(A) SUBMISSION.—

''(i) IN GENERAL.—Subject to subparagraph (B), each entity desiring to serve as a pharmacy contractor under this part in an area shall submit a bid with respect to such area to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(ii) BID THAT COVERS MULTIPLE AREAS.—The Secretary shall permit an entity to submit a single bid for multiple areas if the bid is applicable to all such areas.

''(B) REQUIRED INFORMATION.—The bids described in subparagraph (A) shall include—

''(i) a proposal for the estimated prices of covered outpatient prescription medicines and the projected annual increases in such prices, including the additional reduction in price negotiated below the Secretary's maximum price and differentials between preferred and nonpreferred prices, if applicable;

''(ii) a statement regarding the amount that the entity will charge the Secretary for administering the benefits under the contract;

''(iii) a statement regarding whether the entity will reduce the applicable coinsurance percentage pursuant to section 1859E(a)(1)(A)(ii) and if so, the amount of such reduction and how such reduction is tied to the performance requirements described in subsection (c)(4)(A)(ii);

''(iv) a detailed description of the performance requirements for which the administrative fee of the entity will be subject to risk pursuant to subsection (c)(4)(A)(ii);

''(v) a detailed description of access to pharmacy services provided by the entity, including information regarding whether the pharmacy contractor will use a preferred pharmacy network, and, if so, how the pharmacy contractor will ensure access to pharmacies that choose to be outside of that network, and whether there will be increased cost-sharing for beneficiaries if they obtain medicines at such pharmacies;

''(vi) a detailed description of the procedures and standards the entity will use for—

''(I) selecting preferred prescription medicines; and

''(II) determining when and how often the list of preferred prescription medicines should be modified;

''(vii) a detailed description of any ownership or shared financial interests with pharmaceutical manufacturers, pharmacies, and other entities involved in the administration or delivery of benefits under this part as proposed in the bid;

''(viii) a detailed description of the entity's estimated marketing and advertising expenditures related to enrolling and retaining eligible beneficiaries; and

''(ix) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.

The procedures under clause (vi) shall include the use of a pharmaceutical and therapeutics committee the members of which include practicing pharmacists.

''(8) AWARDING OF CONTRACTS.—

''(A) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goals of providing quality care and of containing costs under this part, award in a competitive manner at least 2 contracts to administer benefits under this part in each area specified under paragraph (6), unless only 1 pharmacy contractor submitting a bid meets the minimum standards specified under this part and by the Secretary.

''(B) DETERMINATION.—In determining which of the pharmacy contractors that submitted bids that meet the minimum standards specified under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of relevant factors, with respect to—

''(i) how well the contractor meets such minimum standards;

''(ii) the amount that the contractor will charge the Secretary for administering the benefits under the contract;

''(iii) the performance standards established under subsection (c)(2) and performance requirements for which the administrative fee of the entity will be subject to risk pursuant to subsection (c)(4)(A)(ii);

''(iv) the proposed negotiated prices of covered outpatient medicines and annual increases in such prices;

''(v) factors relating to benefits, quality and performance, beneficiary cost-sharing, and consumer satisfaction;

''(vi) past performance and prior experience of the contractor in administering a prescription medicine benefit program;

''(vii) effectiveness of the contractor in containing costs through pricing incentives and utilization management; and

''(viii) such other factors as the Secretary deems necessary to evaluate the merits of each bid.

''(C) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts with pharmacy contractors under this part, the Secretary may waive conflict of interest laws generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(i) is not inconsistent with the—

''(I) purposes of the programs under this part; or

''(II) best interests of beneficiaries enrolled under this part; and

''(ii) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the program under this part.

''(D) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of the Secretary to award or not award a contract to a pharmacy contractor under this part shall not be subject to administrative or judicial review.

''(9) ACCESS TO BENEFITS IN CERTAIN AREAS.—

''(A) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient prescription medicines under this part to each eligible beneficiary enrolled under this part that resides in an area that is not covered by any contract under this part.

''(B) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that each eligible beneficiary enrolled under this part that resides in different areas in a year is provided the benefits under this part throughout the entire year.

''(b) QUALITY, FINANCIAL, AND OTHER STANDARDS AND PROGRAMS.—In consultation with appropriate pharmacy contractors, pharmacists, and health care professionals with expertise in prescribing, dispensing, and the appropriate use of prescription medicines, the Secretary shall establish standards and programs for the administration of this part to ensure appropriate prescribing, dispensing, and utilization of outpatient medicines under this part, to avoid adverse medicine reactions, and to continually reduce errors in the delivery of medically appropriate covered benefits. The Secretary shall not award a contract to a pharmacy contractor under this part unless the Secretary finds that the contractor agrees to comply with such standards and programs and other terms and conditions as the Secretary shall specify. The standards and programs under this subsection shall be applied to any administrative agreements described in subsection (a) the Secretary enters into. Such standards and programs shall include the following:

''(1) ACCESS.—

''(A) IN GENERAL.—The pharmacy contractor shall ensure that covered outpatient prescription medicines are accessible and convenient to eligible beneficiaries enrolled under this part for whom benefits are administered by the pharmacy contractor, including by offering the services 24 hours a day and 7 days a week for emergencies.

''(B) ON-LINE REVIEW.—The pharmacy contractor shall provide for on-line prospective review available 24 hours a day and 7 days a week in order to evaluate each prescription for medicine therapy problems due to duplication, interaction, or incorrect dosage or duration of therapy.

''(C) GUARANTEED ACCESS TO MEDICINES IN RURAL AND HARD-TO-SERVE AREAS.—The Secretary shall ensure that all beneficiaries have guaranteed access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas, including through the use of incentives such as bonus payments to retail pharmacists in rural areas and extra payments to the pharmacy contractor for the cost of rapid delivery of pharmaceuticals and any other actions necessary.

''(D) PREFERRED PHARMACY NETWORKS.—

''(i) IN GENERAL.—If a pharmacy contractor uses a preferred pharmacy network to deliver benefits under this part, such network shall meet minimum access standards established by the Secretary.

''(ii) STANDARDS.—In establishing standards under clause (i), the Secretary shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(E) ADHERENCE TO NEGOTIATED PRICES.—The pharmacy contractor shall have in place procedures to assure compliance of pharmacies with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices).

''(F) CONTINUITY OF CARE.—

''(i) IN GENERAL.—The pharmacy contractor shall ensure that, in the case of an eligible beneficiary who loses coverage under this part with such entity under circumstances that would permit a special election period (as established by the Secretary under section 1859C(b)(3)), the contractor will continue to provide coverage under this part to such beneficiary until the beneficiary enrolls and receives such coverage with another pharmacy contractor under this part or, if eligible, with a Medicare+Choice organization.

''(ii) LIMITED PERIOD.—In no event shall a pharmacy contractor be required to provide the extended coverage required under clause (i) beyond the date which is 30 days after the coverage with such contractor would have terminated but for this subparagraph.

''(2) ENROLLEE GUIDELINES.—The pharmacy contractor shall, consistent with State law, apply guidelines for counseling enrollees regarding—

''(A) the proper use of covered outpatient prescription medicine: and

''(B) interactions and contra-indications.

''(3) EDUCATION.—The pharmacy contractor shall apply methods to identify and educate providers, pharmacists, and enrollees regarding—

''(A) instances or patterns concerning the unnecessary or inappropriate prescribing or dispensing of covered outpatient prescription medicines;

''(B) instances or patterns of substandard care;

''(C) potential adverse reactions to covered outpatient prescription medicines;

''(D) inappropriate use of antibiotics;

''(E) appropriate use of generic products; and

''(F) the importance of using covered outpatient prescription medicines in accordance with the instruction of prescribing providers.

''(4) COORDINATION.—The pharmacy contractor shall coordinate with State prescription medicine programs, other pharmacy contractors, pharmacies, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

''(5) COST DATA.—

''(A) The pharmacy contractor shall make data on prescription medicine negotiated prices (including data on discounts) available to the Secretary.

''(B) The Secretary shall require, either directly or through a pharmacy contractor, that participating pharmacists, physicians, and manufacturers—

''(i) maintain their prescription medicine cost data (including data on discounts) in a form and manner specified by the Secretary;

''(ii) make such prescription medicine cost data available for review and audit by the Secretary; and

''(iii) certify that the prescription medicine cost data are current, accurate, and complete, and reflect all discounts obtained by the pharmacist or physician in the purchasing of covered outpatient prescription medicines.

Discounts referred to in subparagraphs (A) and (B) shall include all volume discounts, manufacturer rebates, prompt payment discounts, free goods, in-kind services, or any other thing of financial value provided explicitly or implicitly in exchange for the purchase of a covered outpatient prescription medicine.

''(6) REPORTING.—The pharmacy contractor shall provide the Secretary with periodic reports on—

''(A) the contractor's costs of administering this part;

''(B) utilization of benefits under this part;

''(C) marketing and advertising expenditures related to enrolling and retaining individuals under this part; and

''(D) grievances and appeals.

''(7) RECORDS AND AUDITS.—The pharmacy contractor shall maintain adequate records related to the administration of benefits under this part and afford the Secretary access to such records for auditing purposes.

''(8) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The pharmacy contractor shall comply with requirements of

section 1851(h) (relating to marketing material and application forms) with respect to this part in the same manner as such requirements apply under part C, except that the provisions of paragraph (4)(A) of such section shall not apply with respect to discounts or rebates provided in accordance with this part.

''(c) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—

''(1) IN GENERAL.—The Secretary shall include in a contract awarded under subsection (b) with a pharmacy contractor such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate. The contract may provide financial or other incentives to encourage greater savings to the program under this part.

''(2) PERFORMANCE STANDARDS.—The Secretary shall provide for performance standards (which may include monetary bonuses if the standards are met and penalties if the standards are not met), including standards relating to the time taken to answer member and pharmacy inquiries (written or by telephone), the accuracy of responses, claims processing accuracy, online system availability, appeal procedure turnaround time, system availability, the accuracy and timeliness of reports, and level of beneficiary satisfaction.

''(3) OTHER INCENTIVES.—Such incentives under this subsection may also include—

''(A) financial incentives under which savings derived from the substitution of generic and other preferred multi-source medicines in lieu of nongeneric and nonpreferred medicines are made available to pharmacy contractors, pharmacies, beneficiaries, and the Federal Medicare Prescription Medicine Trust Fund; and

''(B) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization or improving quality that does not reduce the access of beneficiaries to medically necessary covered outpatient medicines.

''(4) REQUIREMENTS FOR PROCEDURES.—

''(A) IN GENERAL.—The Secretary shall establish procedures for making payments to each pharmacy contractor with a contract under this part for the administration of the benefits under this part. The procedures shall provide for the following:

''(i) ADMINISTRATIVE PAYMENT.—Payment of administrative fees for such administration.

''(ii) RISK REQUIREMENT.—An adjustment of a percentage (determined under subparagraph (B)) of the administrative fee payments made to a pharmacy contractor to ensure that the contractor, in administering the benefits under this part, pursues performance requirements established by the Secretary, including the following:

''(I) QUALITY SERVICE.—The contractor provides eligible beneficiaries for whom it administers benefits with quality services, as measured by such factors as sustained pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and member service support access, and timely action with regard to appeals and current beneficiary service surveys.

''(II) QUALITY CLINICAL CARE.—The contractor provides such beneficiaries with quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse drug reactions and reduce medication errors and specific clinical suggestions to improve health and patient and prescriber education as appropriate.

''(III) CONTROL OF MEDICARE COSTS.—The contractor contains costs under this part to the Federal Medicare Prescription Medicine Trust Fund and enrollees, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of beneficiaries to medically necessary covered outpatient prescription medicines.

''(B) PERCENTAGE OF PAYMENT TIED TO RISK.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the percentage of the administrative payments to a pharmacy contractor that will be tied to the performance requirements described in subparagraph (A)(ii).

''(ii) LIMITATION ON RISK TO ENSURE PROGRAM STABILITY.—In order to provide for program stability, the Secretary may not establish a percentage to be adjusted under this paragraph at a level that jeopardizes the ability of a pharmacy contractor to administer the benefits under this part or administer such benefits in a quality manner.

''(C) RISK ADJUSTMENT OF PAYMENTS BASED ON ENROLLEES IN PLAN.—To the extent that a pharmacy contractor is at risk under this paragraph, the procedures established under this paragraph may include a methodology for risk adjusting the payments made to such contractor based on the differences in actuarial risk of different enrollees being served if the Secretary determines such adjustments to be necessary and appropriate.

''(d) AUTHORITY RELATING TO PHARMACY PARTICIPATION.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a pharmacy contractor may establish consistent with this part conditions for the participation of pharmacies, including conditions relating to quality (including reduction of medical errors) and technology.

''(2) AGREEMENTS WITH PHARMACIES.—Each pharmacy contractor shall enter into a participation agreement with any pharmacy that meets the requirements of this subsection and section 1859E to furnish covered outpatient prescription medicines to individuals enrolled under this part.

''(3) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and conditions:

''(A) APPLICABLE REQUIREMENTS.—The pharmacy shall meet (and throughout the contract period continue to meet) all applicable Federal requirements and State and local licensing requirements.

''(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Secretary (and such a pharmacy contractor) shall establish concerning the quality of, and enrolled individuals' access to, pharmacy services under this part. Such standards shall require the pharmacy—

''(i) not to refuse to dispense covered outpatient prescription medicines to any individual enrolled under this part;

''(ii) to keep patient records (including records on expenses) for all covered outpatient prescription medicines dispensed to such enrolled individuals;

''(iii) to submit information (in a manner specified by the Secretary to be necessary to administer this part) on all purchases of such medicines dispensed to such enrolled individuals; and

''(iv) to comply with periodic audits to assure compliance with the requirements of this part and the accuracy of information submitted.

''(C) ADHERENCE TO NEGOTIATED PRICES.—(i) The total charge for each medicine dispensed by the pharmacy to an enrolled individual under this part, without regard to whether the individual is financially responsible for any or all of such charge, shall not exceed the price negotiated under section 1859A(a) or, if lower, negotiated under subsection (a)(5) (or, if less, the retail price for the medicine involved) with respect to such medicine plus a reasonable dispensing fee determined contractually with the pharmacy contractor.

''(ii) The pharmacy does not charge (or collect from) an enrolled individual an amount that exceeds the individual's obligation (as determined in accordance with the provisions of this part) of the applicable price described in clause (i).

''(D) ADDITIONAL REQUIREMENTS.—The pharmacy shall meet such additional contract requirements as the applicable pharmacy contractor specifies under this section.

''(4) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to pharmacies participating in the program under this part.

''ELIGIBILITY; VOLUNTARY ENROLLMENT; COVERAGE

''SEC. 1859C. (a) ELIGIBILITY.—Each individual who is entitled to hospital insurance benefits under part A or is eligible to be enrolled in the medical insurance program under part B is eligible to enroll in accordance with this section for outpatient prescription medicine benefits under this part.

''(b) VOLUNTARY ENROLLMENT.—

''(1) IN GENERAL.—An individual may enroll under this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this subsection.

''(2) INITIAL ENROLLMENT PERIOD.—

''(A) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who satisfies subsection (a) as of November 1, 2005, the initial general enrollment period shall begin on August 1, 2005, and shall end on March 1, 2006.

''(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who first satisfies subsection (a) on or after November 1, 2005, the individual's initial enrollment period shall begin on the first day of the third month before the month in which such individual first satisfies such paragraph and shall end seven months later. The Secretary shall apply rules similar to the rule described in the second sentence of section 1837(d).

''(3) SPECIAL ENROLLMENT PERIODS (WITHOUT PREMIUM PENALTY).—

''(A) EMPLOYER COVERAGE AT TIME OF INITIAL GENERAL ENROLLMENT PERIOD.—In the case of an individual who—

''(i) at the time the individual first satisfies subsection (a) is enrolled in a group health plan (including continuation coverage) that provides outpatient prescription medicine coverage by reason of the individual's (or the individual's spouse's) current (or, in the case of continuation coverage, former) employment status, and

''(ii) has elected not to enroll (or to be deemed enrolled) under this subsection during the individual's initial enrollment period,

there shall be a special enrollment period of 6 months beginning with the first month that includes the date of the individual's (or individual's spouse's) retirement from or termination of current employment status with the employer that sponsors the plan, or, in the case of continuation coverage, that includes the date of termination of such coverage, or that includes the date the plan substantially terminates outpatient prescription medicine coverage.

''(B) DROPPING OF RETIREE PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who—

''(i) at the time the individual first satisfies subsection (a) is enrolled in a group health plan that provides outpatient prescription medicine coverage other than by reason of the individual's (or the individual's spouse's) current employment; and

''(ii) has elected not to enroll (or to be deemed enrolled) under this subsection during the individual's initial enrollment period,

there shall be a special enrollment period of 6 months beginning with the first month that includes the date that the plan substantially terminates outpatient prescription medicine coverage and ending 6 months later.

''(C) LOSS OF MEDICARE+CHOICE PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who is enrolled under part C in a Medicare+Choice plan that provides prescription medicine benefits, if such enrollment is terminated because of the termination or reduction in service area of the plan, there shall be a special enrollment period of 6 months beginning with the first month that includes the date that such plan is terminated or such reduction occurs and ending 6 months later.

''(D) LOSS OF MEDICAID PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who—

''(i) satisfies subsection (a);

''(ii) loses eligibility for benefits (that include benefits for prescription medicine) under a State plan after having been enrolled (or determined to be eligible) for such benefits under such plan; and

''(iii) is not otherwise enrolled under this subsection at the time of such loss of eligibility,

there shall be a special enrollment period specified by the Secretary of not less than 6 months beginning with the first month that includes the date that the individual loses such eligibility.

''(4) LATE ENROLLMENT WITH PREMIUM PENALTY.—The Secretary shall permit an individual who satisfies subsection (a) to enroll other than during the initial enrollment period under paragraph (2) or a special enrollment period under paragraph (3). But, in the case of such an enrollment, the amount of the monthly premium of the individual is subject to an increase under section 1859C(e)(1).

''(5) INFORMATION.—

''(A) IN GENERAL.—The Secretary shall broadly distribute information to individuals who satisfy subsection (a) on the benefits provided under this part. The Secretary shall periodically make available information on the cost differentials to enrollees for the use of generic medicines and other medicines.

''(B) TOLL-FREE HOTLINE.—The Secretary shall maintain a toll-free telephone hotline (which may be a hotline already used by the Secretary under this title) for purposes of providing assistance to beneficiaries in the program under this part, including responding to questions concerning coverage, enrollment, benefits, grievances and appeals procedures, and other aspects of such program.

''(6) ENROLLEE DEFINED.—For purposes of this part, the term 'enrollee' means an individual enrolled for benefits under this part.

''(c) COVERAGE PERIOD.—

''(1) IN GENERAL.—The period during which an individual is entitled to benefits under this part (in this subsection referred to as the individual's 'coverage period') shall begin on such a date as the Secretary shall establish consistent with the type of coverage rules described in subsections (a) and (e) of section 1838, except that in no case shall a coverage period begin before January 1, 2006. No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period.

''(2) TERMINATION.—The Secretary shall provide for the application of provisions under this subsection similar to the provisions in section 1838(b).

''(d) PROVISION OF BENEFITS TO MEDICARE+CHOICE ENROLLEES.—In the case of an individual who is enrolled under this part and is enrolled in a Medicare+Choice plan under part C, the individual shall be provided the benefits under this part through such plan and not through payment under this part.

''(e) LATE ENROLLMENT PENALTIES; PAYMENT OF PREMIUMS.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) IN GENERAL.—In the case of a late enrollment described in subsection (b)(4), subject to the succeeding provisions of this paragraph, the Secretary shall establish procedures for increasing the amount of the monthly premium under this part applicable to such enrollee by an amount that the Secretary determines is actuarially sound for each such period.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account months of lapsed coverage in a manner comparable to that applicable under the second sentence of section 1839(b).

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the enrollee can demonstrate that the enrollee was covered under a group health plan that provides coverage of the cost of prescription medicines whose actuarial value (as defined by the Secretary) to the enrollee equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription medicine benefit program under this part.

''(ii) APPLICATION.—This subparagraph shall only apply with respect to a coverage period the enrollment for which occurs before the end of the 60-day period that begins on the first day of the month which includes the date on which the plan terminates or reduces its service area (in a manner that results in termination of enrollment), ceases to provide, or reduces the value of the prescription medicine coverage under such plan to below the value of the coverage provided under the program under this part.

''(2) INCORPORATION OF PREMIUM PAYMENT AND GOVERNMENT CONTRIBUTIONS PROVISIONS.—The provisions of sections 1840 and 1844(a)(1) shall apply to enrollees under this part in the same manner as they apply to individuals 65 years of age or older enrolled under part B. For purposes of this subsection, any reference in a section referred to in a previous subsection to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Federal Medicare Prescription Medicine Trust Fund.

''(f) ELECTION OF PHARMACY CONTRACTOR TO ADMINISTER BENEFITS.—The Secretary shall establish a process whereby each individual enrolled under this part and residing in a region may elect the pharmacy contractor that will administer the benefits under this part with respect to the individual. Such process shall permit the individual to make an initial election and to change such an election on at least an annual basis and under such other circumstances as the Secretary shall specify.

''PROVISION OF, AND ENTITLEMENT TO, BENEFITS

''SEC. 1859D. (a) BENEFITS.—Subject to the succeeding provisions of this section, the benefits provided to an enrollee by the program under this part shall consist of the following:

''(1) COVERED OUTPATIENT PRESCRIPTION MEDICINE BENEFITS.—Entitlement to have payment made on the individual's behalf for covered outpatient prescription medicines.

''(2) LIMITATION ON COST-SHARING FOR PART B OUTPATIENT PRESCRIPTION MEDICINES.—

''(A) IN GENERAL.—Once an enrollee has incurred aggregate countable cost-sharing (as defined in subparagraph (B)) equal to the stop-loss limit specified in subsection (c)(4) for expenses in a year, entitlement to the elimination of cost-sharing otherwise applicable under part B for additional expenses incurred in the year for outpatient prescription medicines or biologicals for which payment is made under part B.

''(B) COUNTABLE COST-SHARING DEFINED.—For purposes of this part, the term 'countable cost-sharing' means—

''(i) out-of-pocket expenses for outpatient prescription medicines with respect to which benefits are payable under part B, and

''(ii) cost-sharing under subsections (c)(3)(B) and (c)(3)(C)(i).

''(b) COVERED OUTPATIENT PRESCRIPTION MEDICINE DEFINED.—

''(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of this part the term 'covered outpatient prescription medicine' means any of the following products:

''(A) A medicine which may be dispensed only upon prescription, and—

''(i) which is approved for safety and effectiveness as a prescription medicine under section 505 of the Federal Food, Drug, and Cosmetic Act;

''(ii)(I) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a medicine, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

''(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a medicine, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such medicine under such section because the Secretary has determined that the medicine is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(B) A biological product which—

''(i) may only be dispensed upon prescription;

''(ii) is licensed under section 351 of the Public Health Service Act; and

''(iii) is produced at an establishment licensed under such section to produce such product.

''(C) Insulin approved under appropriate Federal law, and needles, syringes, and disposable pumps for the administration of such insulin.

''(D) A prescribed medicine or biological product that would meet the requirements of subparagraph (A) or (B) but that is available over-the-counter in addition to being available upon prescription, but only if the particular dosage form or strength prescribed and required for the individual is not available over-the-counter.

''(E) Smoking cessation agents (as specified by the Secretary).

''(2) EXCLUSION.—The term 'covered outpatient prescription medicine' does not include—

''(A) medicines or classes of medicines, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), as the Secretary may specify and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this part;

''(B) except as provided in paragraphs (1)(D) and (1)(E), any product which may be distributed to individuals without a prescription;

''(C) any product when furnished as part of, or as incident to, a diagnostic service or any other item or service for which payment may be made under this title; or

''(D) any product that is covered under part B of this title.

''(c) PAYMENT OF BENEFITS.—

''(1) COVERED OUTPATIENT PRESCRIPTION MEDICINES.—There shall be paid from the Federal Medicare Prescription Medicine Trust Fund, in the case of each enrollee who incurs expenses for medicines with respect to which benefits are payable under this part under subsection (a)(1), amounts equal to the sum of—

''(A) the price for which the medicine is made available under this part (consistent with sections 1859A and 1859B), reduced by any applicable cost-sharing under paragraphs (2) and (3); and

''(B) a reasonable dispensing fee.

The price under subparagraph (A) shall in no case exceed the retail price for the medicine involved.

''(2) DEDUCTIBLE.—The amount of payment under paragraph (1) for expenses incurred in a year, beginning with 2006, shall be reduced by an annual deductible equal to the amount specified in section 1859(2) (subject to adjustment under paragraph (8)). Only expenses for countable cost-sharing (as defined in subsection (a)(2)(B)) shall be taken into account in applying this paragraph.

''(3) COINSURANCE.—

''(A) IN GENERAL.—The amount of payment under paragraph (1) for expenses incurred in a year shall be further reduced (subject to the stop-loss limit under paragraph (4)) by coinsurance as provided under this paragraph.

''(B) PREFERRED MEDICINES.—The coinsurance under this paragraph in the case of a preferred medicine (including a medicine treated as a preferred medicine under paragraph (5)), is equal to 20 percent of the price applicable under paragraph (1)(A) (or such lower percentage as may be provided for under section 1859E(a)(1)(A)(ii)). In this part, the term 'preferred medicine' means, with respect to medicines classified within a therapeutic class, those medicines which have been designated as a preferred medicine by the Secretary or the pharmacy contractor involved with respect to that class and (in the case of a nongeneric medicine) with respect to which a contract has been negotiated under this part.

''(C) NONPREFERRED MEDICINES.—The coinsurance under this paragraph in the case of a nonpreferred medicine that is not treated as a preferred medicine under paragraph (5) is equal to the sum of—

''(i) 20 percent of the price for lowest price preferred medicine that is within the same therapeutic class; and

''(ii) the amount by which—

''(I) the price at which the nonpreferred medicine is made available to the enrollee; exceeds

''(II) the price of such lowest price preferred medicine.

''(4) NO COINSURANCE ONCE OUT-OF-POCKET EXPENDITURES EQUAL STOP-LOSS LIMIT.—Once an enrollee has incurred aggregate countable cost-sharing under paragraph (3) (including cost-sharing under part B attributable to outpatient prescription drugs or biologicals) equal to the amount specified in section 1859(4) (subject to adjustment under paragraph (8)) for expenses in a year—

''(A) there shall be no coinsurance under paragraph (3) for additional expenses incurred in the year involved; and

''(B) there shall be no coinsurance under part B for additional expenses incurred in the year involved for outpatient prescription drugs and biologicals.

''(5) APPEALS RIGHTS RELATING TO COVERAGE OF NONPREFERRED MEDICINES.—

''(A) PROCEDURES REGARDING THE DETERMINATION OF MEDICINES THAT ARE MEDICALLY NECESSARY.—Each pharmacy contractor shall have in place procedures on a case-by-case basis to treat a nonpreferred medicine as a preferred medicine under this part if the preferred medicine is determined to be not as effective for the enrollee or to have significant adverse effect on the enrollee. Such procedures shall require that such determinations are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

''(B) PROCEDURES REGARDING DENIALS OF CARE.—Such contractor shall have in place procedures to ensure—

''(i) a timely internal review for resolution of denials of coverage (in whole or in part and including those regarding the coverage of nonpreferred medicines) in accordance with the medical exigencies of the case and a timely resolution of complaints, by enrollees in the plan, or by providers, pharmacists, and other individuals acting on behalf of each such enrollee (with the enrollee's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C;

''(ii) that the entity complies in a timely manner with requirements established by the Secretary that (I) provide for an external review by an independent entity selected by the Secretary of denials of coverage described in clause (i) not resolved in the favor of the beneficiary (or other complainant) under the process described in such clause and (II) are comparable to the external review requirements established for Medicare+Choice organizations under part C; and

''(iii) that enrollees are provided with information regarding the appeals procedures under this part at the time of enrollment with a pharmacy contractor under this part and upon request thereafter.

''(6) TRANSFER OF FUNDS TO COVER COSTS OF PART B PRESCRIPTION MEDICINE CATASTROPHIC BENEFIT.—With respect to benefits described in subsection (a)(2), there shall transferred from the Federal Medicare Prescription Medicine Trust Fund to the Federal Supplementary Medical Insurance Trust Fund amounts equivalent to the elimination of cost-sharing described in such subsection.

''(7) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—For purposes of making payment under part B for medicines that would be covered outpatient prescription medicines but for the exclusion under subparagraph (B) or (C) of subsection (b)(2), the Secretary may elect to apply the payment basis used for payment of covered outpatient prescription medicines under this part instead of the payment basis otherwise used under such part, if it results in a lower cost to the program.

''(8) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—With respect to expenses incurred in a year after 2006—

''(i) the deductible under paragraph (2) is equal to the deductible determined under such paragraph (or this subparagraph) for the previous year increased by the percentage increase in per capita program expenditures (as estimated in advance for the year involved under subparagraph (B)); and

''(ii) the stop-loss limit under paragraph (3) is equal to the stop-loss limit determined under such paragraph (or this subparagraph) for the previous year increased by such percentage increase.

The Secretary shall adjust such percentage increase in subsequent years to take into account misestimations made of the per capita program expenditures under clauses (i) and (ii) in previous years. Any increase under this subparagraph that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(B) ESTIMATION OF INCREASE IN PER CAPITA PROGRAM EXPENDITURES.—The Secretary shall before the beginning of each year (beginning with 2007) estimate the percentage increase in average per capita aggregate expenditures from the Federal Medicare Prescription Medicine Trust Fund for the year involved compared to the previous year.

''(C) RECONCILIATION.—The Secretary shall also compute (beginning with 2008) the actual percentage increase in such aggregate expenditures in order to provide for reconciliation of deductibles, stop-loss limits, and premiums under the second sentence of subparagraph (A) and under section 1859D(d)(2).

''(d) AMOUNT OF PREMIUMS.—

''(1) MONTHLY PREMIUM RATE IN 2006.—The monthly premium rate in 2006 for prescription medicine benefits under this part is the amount specified in section 1859(1).

''(2) INFLATION ADJUSTMENT FOR SUBSEQUENT YEARS.—The monthly premium rate for a year after 2006 for prescription medicine benefits under this part is equal to the monthly premium rate for the previous year under this subsection increased by the percentage increase in per capita program expenditures (as estimated in advance for the year involved under subsection (c)(8)(B)). The Secretary shall adjust such percentage in subsequent years to take into account misestimations made of the per capita program expenditures under the previous sentence in previous years. Any increase under this paragraph that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''ADMINISTRATION; QUALITY ASSURANCE

''SEC. 1859E. (a) RULES RELATING TO PROVISION OF BENEFITS.—

''(1) PROVISION OF BENEFITS.—

''(A) IN GENERAL.—In providing benefits under this part, the Secretary (directly or through the contracts with pharmacy contractors) shall employ mechanisms to provide benefits appropriately and efficiently, and those mechanisms may include—

''(i) the use of—

''(I) price negotiations (consistent with subsection (b));

''(II) reduced coinsurance (below 20 percent) to encourage the utilization of appropriate preferred medicines; and

''(III) methods to reduce medication errors and encourage appropriate use of medications; and

''(ii) permitting pharmacy contractors, as approved by the Secretary, to make exceptions to section 1859D(c)(3)(C) (relating to cost-sharing for non-preferred medicines) to secure best prices for enrollees so long as the payment amount under section 1859D(c)(1) does not equal zero.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to prevent the Secretary (directly or through the contracts with pharmacy contractors) from using incentives to encourage enrollees to select generic or other cost-effective medicines, so long as—

''(i) such incentives are designed not to result in any increase in the aggregate expenditures under the Federal Medicare Prescription Medicine Trust Fund; and

''(ii) a beneficiary's coinsurance shall be no greater than 20 percent in the case of a preferred medicine (including a nonpreferred medicine treated as a preferred medicine under section 1859D(c)(5)).

''(2) CONSTRUCTION.—Nothing in this part shall preclude the Secretary or a pharmacy contractor from—

''(A) educating prescribing providers, pharmacists, and enrollees about medical and cost benefits of preferred medicines;

''(B) requesting prescribing providers to consider a preferred medicine prior to dispensing of a nonpreferred medicine, as long as such request does not unduly delay the provision of the medicine;

''(C) using mechanisms to encourage enrollees under this part to select cost-effective medicines or less costly means of receiving or administering medicines, including the use of therapeutic interchange programs, disease management programs, and notification to the beneficiary that a more affordable generic medicine equivalent was not selected by the prescribing provider and a statement of the lost cost savings to the beneficiary;

''(D) using price negotiations to achieve reduced prices on covered outpatient prescription medicines, including new medicines, medicines for which there are few therapeutic alternatives, and medicines of particular clinical importance to individuals enrolled under this part; and

''(E) utilizing information on medicine prices of OECD countries and of other payors in the United States in the negotiation of prices under this part.

''(b) PRICE NEGOTIATIONS PROCESS.—

''(1) REQUIREMENTS WITH RESPECT TO PREFERRED MEDICINES.—Negotiations of contracts with manufacturers with respect to covered outpatient prescription medicines under this part shall be conducted in a manner so that—

''(A) there is at least a contract for a medicine within each therapeutic class (as defined by the Secretary in consultation with such Medicare Prescription Medicine Advisory Committee);

''(B) if there is more than 1 medicine available in a therapeutic class, there are contracts for at least 2 medicines within such class unless determined clinically inappropriate in accordance with standards established by the Secretary; and

''(C) if there are more than 2 medicines available in a therapeutic class, there is a contract for at least 2 medicines within such class and a contract for generic medicine substitute if available unless determined clinically inappropriate in accordance with standards established by the Secretary.

''(2) ESTABLISHMENT OF THERAPEUTIC CLASSES.—The Secretary, in consultation with the Medicare Prescription Medicine Advisory Committee (established under section 1859H), shall establish for purposes of this part therapeutic classes and assign to such classes covered outpatient prescription medicines.

''(3) DISCLOSURE CONCERNING PREFERRED MEDICINES.—The Secretary shall provide, through pharmacy contractors or otherwise, for—

''(A) disclosure to current and prospective enrollees and to participating providers and pharmacies in each service area a list of the preferred medicines and differences in applicable cost-sharing between such medicines and nonpreferred medicines; and

''(B) advance disclosure to current enrollees and to participating providers and pharmacies in each service area of changes to any such list of preferred medicines and differences in applicable cost-sharing.

''(4) NO REVIEW.—The Secretary's establishment of therapeutic classes and the assignment of medicines to such classes and the Secretary's determination of what is a breakthrough medicine are not subject to administrative or judicial review.

''(c) CONFIDENTIALITY.—The Secretary shall ensure that the confidentiality of individually identifiable health information relating to the provision of benefits under this part is protected, consistent with the standards for the privacy of such information promulgated by the Secretary under the Health Insurance Portability and Accountability Act of 1996, or any subsequent comprehensive and more protective set of confidentiality standards enacted into law or promulgated by the Secretary. Nothing in this subsection shall be construed as preventing the coordination of data with a State prescription medicine program so long as such program has in place confidentiality standards that are equal to or exceed the standards used by the Secretary.

''(d) FRAUD AND ABUSE SAFEGUARDS.—The Secretary, through the Office of the Inspector General, is authorized and directed to issue regulations establishing appropriate safeguards to prevent fraud and abuse under this part. Such safeguards, at a minimum, should include compliance programs, certification data, audits, and recordkeeping practices. In developing such regulations, the Secretary shall consult with the Attorney General and other law enforcement and regulatory agencies.

''FEDERAL MEDICARE PRESCRIPTION MEDICINE TRUST FUND

''SEC. 1859F. (a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Prescription Medicine Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

''(b) APPLICATION OF SMI TRUST FUND PROVISIONS.—The provisions of subsections (b) through (i) of section 1841 shall apply to this part and the Trust Fund in the same manner as they apply to part B and the Federal Supplementary Medical Insurance Trust Fund, respectively.

''COMPENSATION FOR EMPLOYERS COVERING RETIREE MEDICINE COSTS

''SEC. 1859G. (a) IN GENERAL.—In the case of an individual who is eligible to be enrolled under this part and is a participant or beneficiary under a group health plan that provides outpatient prescription medicine coverage to retirees the actuarial value of which is not less than the actuarial value of the coverage provided under this part, the Secretary shall make payments to such plan subject to the provisions of this section. Such payments shall be treated as payments under this part for purposes of sections 1859F and 1859C(e)(2). In applying the previous sentence with respect to section 1859C(e)(2), the amount of the Government contribution referred to in section 1844(a)(1)(A) is deemed to be equal to the aggregate amount of the payments made under this section.

''(b) REQUIREMENTS.—To receive payment under this section, a group health plan shall comply with the following requirements:

''(1) COMPLIANCE WITH REQUIREMENTS.—The group health plan shall comply with the requirements of this Act and other reasonable, necessary, and related requirements that are needed to administer this section, as determined by the Secretary.

''(2) ANNUAL ASSURANCES AND NOTICE BEFORE TERMINATION.—The sponsor of the plan shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered under the group health plan meets the requirements of this section and will continue to meet such requirements for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered enrollees—

''(i) at least 120 days before terminating its plan, and

''(ii) immediately upon determining that the actuarial value of the prescription medicine benefit under the plan falls below the actuarial value required under subsection (a).

''(3) BENEFICIARY INFORMATION.—The sponsor of the plan shall report to the Secretary, for each calendar quarter for which it seeks a payment under this section, the names and social security numbers of all enrollees described in subsection (a) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(4) AUDITS.—The sponsor or plan seeking payment under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription medicine coverage, the accuracy of payments made, and such other matters as may be appropriate.

''(c) PAYMENT.—

''(1) IN GENERAL.—The sponsor of a group health plan that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made on a quarterly basis of the amount specified in paragraph (2) for each individual described in subsection (a) who during the quarter is covered under the plan and was not enrolled in the insurance program under this part.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment for a quarter shall approximate, for each such covered individual, ⅔ of the sum of the monthly Government contribution amounts (computed under subparagraph (B)) for each of the 3 months in the quarter.

''(B) COMPUTATION OF MONTHLY GOVERNMENT CONTRIBUTION AMOUNT.—For purposes of subparagraph (A), the monthly Government contribution amount for a month in a year is equal to the amount by which—

''(i) 1/12 of the average per capita aggregate expenditures, as estimated under section 1859D(c)(8) for the year involved; exceeds

''(ii) the monthly premium rate under section 1859D(d) for the month involved.

''MEDICARE PRESCRIPTION MEDICINE ADVISORY COMMITTEE

''SEC. 1859H. (a) ESTABLISHMENT OF COMMITTEE.—There is established a Medicare Prescription Medicine Advisory Committee (in this section referred to as the 'Committee').

''(b) FUNCTIONS OF COMMITTEE.—The Committee shall advise the Secretary on policies related to—

''(1) the development of guidelines for the implementation and administration of the outpatient prescription medicine benefit program under this part; and

''(2) the development of—

''(A) standards required of pharmacy contractors under section 1859D(c)(5) for determining if a medicine is as effective for an enrollee or has a significant adverse effect on an enrollee under this part;

''(B) standards for—

''(i) defining therapeutic classes;

''(ii) adding new therapeutic classes;

''(iii) assigning to such classes covered outpatient prescription medicines; and

''(iv) identifying breakthrough medicines;

''(C) procedures to evaluate the bids submitted by pharmacy contractors under this part;

''(D) procedures for negotiations, and standards for entering into contracts, with manufacturers, including identifying medicines or classes of medicines where Secretarial negotiation is most likely to yield savings under this part significantly above those that which could be achieved by a pharmacy contractor; and

''(E) procedures to ensure that pharmacy contractors with a contract under this part are in compliance with the requirements under this part.

For purposes of this part, a medicine is a 'breakthrough medicine' if the Secretary, in consultation with the Committee, determines it is a new product that will make a significant and major improvement by reducing physical or mental illness, reducing mortality, or reducing disability, and that no other product is available to beneficiaries that achieves similar results for the same condition. The Committee may consider cost-effectiveness in establishing standards for defining therapeutic classes and assigning drugs to such classes under subparagraph (B).

''(c) STRUCTURE AND MEMBERSHIP OF THE COMMITTEE.—

''(1) STRUCTURE.—The Committee shall be composed of 19 members who shall be appointed by the Secretary.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Committee.

''(B) SPECIFIC MEMBERS.—Of the members appointed under paragraph (1)—

''(i) 5 shall be chosen to represent practicing physicians, 2 of whom shall be gerontologists;

''(ii) 2 shall be chosen to represent practicing nurse practitioners;

''(iii) 4 shall be chosen to represent practicing pharmacists;

''(iv) 1 shall be chosen to represent the Centers for Medicare & Medicaid Services;

''(v) 4 shall be chosen to represent actuaries, pharmacoeconomists, researchers, and other appropriate experts;

''(vi) 1 shall be chosen to represent emerging medicine technologies;

''(vii) 1 shall be chosen to represent the Food and Drug Administration; and

''(viii) 1 shall be chosen to represent individuals enrolled under this part.

''(d) TERMS OF APPOINTMENT.—Each member of the Committee shall serve for a term determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on January 1, 2005.

''(e) CHAIRPERSON.—The Secretary shall designate a member of the Committee as Chairperson. The term as Chairperson shall be for a 1-year period.

''(f) COMMITTEE PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—The members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

''(2) STAFF.—The Committee may appoint such personnel as the Committee considers appropriate.

''(g) OPERATION OF THE COMMITTEE.—

''(1) MEETINGS.—The Committee shall meet at the call of the Chairperson (after consultation with the other members of the Committee) not less often than quarterly to consider a specific agenda of issues, as determined by the Chairperson after such consultation.

''(2) QUORUM.—Ten members of the Committee shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(i) TRANSFER OF PERSONNEL, RESOURCES, AND ASSETS.—For purposes of carrying out its duties, the Secretary and the Committee may provide for the transfer to the Committee of such civil service personnel in the employ of the Department of Health and Human Services (including the Centers for Medicare & Medicaid Services), and such resources and assets of the Department used in carrying out this title, as the Committee requires.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(b) APPLICATION OF GENERAL EXCLUSIONS FROM COVERAGE.—

(1) APPLICATION TO PART D.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(2) PRESCRIPTION MEDICINES NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (H), by striking ''and'' at the end;

(B) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(J) in the case of prescription medicines covered under part D, which are not prescribed in accordance with such part;''.

(c) CONFORMING AMENDMENTS.—(1) Part C of title XVIII is amended—

(A) in section 1851(a)(2)(B) (42 U.S.C. 1395w–21(a)(2)(B)), by striking ''1859(b)(3)'' and inserting ''1858(b)(3)'';

(B) in section 1851(a)(2)(C) (42 U.S.C. 1395w–21(a)(2)(C)), by striking ''1859(b)(2)'' and inserting ''1858(b)(2)'';

(C) in section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)), by striking ''1859(b)(3)'' and inserting ''1858(b)(3)'';

(D) in section 1852(a)(3)(B)(ii) (42 U.S.C. 1395w–22(a)(3)(B)(ii)), by striking ''1859(b)(2)(B)'' and inserting ''1858(b)(2)(B)'';

(E) in section 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A)), by striking ''1859(e)(4)'' and inserting ''1858(e)(4)''; and

(F) in section 1853(a)(3)(D) (42 U.S.C. 1395w–23(a)(3)(D)), by striking ''1859(e)(4)'' and inserting ''1858(e)(4)''.

(2) Section 1171(a)(5)(D) (42 U.S.C. 1320d(a)(5)(D)) is amended by striking ''or (C)'' and inserting ''(C), or (D)''.

SEC. 102. PROVISION OF MEDICARE OUTPATIENT PRESCRIPTION MEDICINE COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) REQUIRING AVAILABILITY OF AN ACTUARIALLY EQUIVALENT PRESCRIPTION MEDICINE BENEFIT.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) AVAILABILITY OF PRESCRIPTION MEDICINE BENEFITS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, each Medicare+Choice organization that makes available a Medicare+Choice plan described in section 1851(a)(2)(A) shall make available such a plan that offers coverage of covered outpatient prescription medicines that is at least actuarially equivalent to the benefits provided under part D. Information respecting such benefits shall be made available in the same manner as information on other benefits provided under this part is made available. Nothing in this paragraph shall be construed as requiring the offering of such coverage separate from coverage that includes benefits under parts A and B.

''(2) TREATMENT OF PRESCRIPTION MEDICINE ENROLLEES.—In the case of a Medicare+Choice eligible individual who is enrolled under part D, the benefits described in paragraph (1) shall be treated in the same manner as benefits described in part B for purposes of coverage and payment and any reference in this part to the Federal Supplementary Medical Insurance Trust Fund shall be deemed, with respect to such benefits, to be a reference to the Federal Medicare Prescription Medicine Trust Fund.''.

(b) APPLICATION OF QUALITY STANDARDS.—Section 1852(e)(2)(A) (42 U.S.C. 1395w–22(e)(2)(A)) is amended—

(1) by striking ''and'' at the end of clause (xi);

(2) by striking the period at the end of clause (xii) and inserting '', and''; and

(3) by adding at the end the following new clause:

''(xiii) comply with the standards, and apply the programs, under section 1859B(b) for covered outpatient prescription medicines under the plan.''.

(c) PAYMENT SEPARATE FROM PAYMENT FOR PART A AND B BENEFITS.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)(1)(A), by striking ''and (i)'' and inserting ''(i), and (j)''; and

(2) by adding at the end the following new subsection:

''(j) PAYMENT FOR PRESCRIPTION MEDICINE COVERAGE OPTION.—

''(1) IN GENERAL.—In the case of a Medicare+Choice plan that provides prescription medicine benefits described in section 1851(j)(1), the amount of payment otherwise made to the Medicare+Choice organization offering the plan shall be increased by the amount described in paragraph (2). Such payments shall be made in the same manner and time as the amount otherwise paid, but such amount shall be payable from the Federal Medicare Prescription Medicine Trust Fund.

''(2) AMOUNT.—The amount described in this paragraph is the monthly Government contribution amount computed under section 1859G(c)(2)(B), but subject to adjustment under paragraph (3). Such amount shall be uniform geographically and shall not vary based on the Medicare+Choice payment area involved.

''(3) RISK ADJUSTMENT.—The Secretary shall establish a methodology for the adjustment of the payment amount under this subsection in a manner that takes into account the relative risks for use of outpatient prescription medicines by Medicare+Choice enrollees. Such methodology shall be designed in a manner so that the total payments under this title (including part D) are not changed as a result of the application of such methodology.''.

(d) SEPARATE APPLICATION OF ADJUSTED COMMUNITY RATE (ACR).—Section 1854 (42 U.S.C. 1395w–24) is amended by adding at the end the following:

''(i) APPLICATION TO PRESCRIPTION MEDICINE COVERAGE.—The Secretary shall apply the previous provisions of this section (including the computation of the adjusted community rate) separately with respect to prescription medicine benefits described in section 1851(j)(1).''.

(f) CONFORMING AMENDMENTS.—

(1) Section 1851 (42 U.S.C. 1395w–21) is amended—

(A) in subsection (a)(1)(A), by striking ''parts A and B'' and inserting ''parts A, B, and D''; and

(B) in subsection (i) by inserting ''(and, if applicable, part D)'' after ''parts A and B''.

(2) Section 1852(a)(1)(A) (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under such part)'' after ''parts A and B''.

(3) Section 1852(d)(1) (42 U.S.C. 1395w–22(d)(1)) is amended—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(C) by adding at the end the following:

''(F) the plan for part D benefits guarantees coverage of any specifically named prescription medicine for an enrollee to the extent that it would be required to be covered under part D.

In carrying out subparagraph (F), a Medicare+Choice organization has the same authority to enter into contracts with respect to coverage of preferred medicines as the Secretary has under part D, but subject to an independent contractor appeal or other appeal process that would be applicable to determinations by such a pharmacy contractor consistent with section 1859D(c)(5).''.

(e) LIMITATION ON COST-SHARING.—Section 1854(e) (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) LIMITATION ON COST-SHARING.—In no event may a Medicare+Choice organization include a requirement that an enrollee pay cost-sharing in excess of the cost-sharing otherwise permitted under part D.''.

SEC. 103. MEDIGAP REVISIONS.

(a) REQUIRED COVERAGE OF COVERED OUTPATIENT PRESCRIPTION MEDICINES.—Section 1882(p)(2)(B) (42 U.S.C. 1395ss(p)(2)(B)) is amended by inserting before ''and'' at the end the following: ''including a requirement that an appropriate number of policies provide coverage of medicines which complements but does not duplicate the medicine benefits that beneficiaries are otherwise eligible for benefits under part D of this title (with the Secretary and the National Association of Insurance Commissioners determining the appropriate level of medicine benefits that each benefit package must provide and ensuring that policies providing such coverage are affordable for beneficiaries;''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2006.

(c) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the amendments made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section; but

(ii) having a legislature which is not scheduled to meet in 2004 in a legislative session in which such legislation may be considered;

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 2004. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 104. TRANSITIONAL ASSISTANCE FOR LOW INCOME BENEFICIARIES.

(a) QMB COVERAGE OF PREMIUMS AND COST-SHARING.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and'' at the end of clause (i),

(B) by adding ''and'' at the end of clause (ii), and

(C) by adding at the end the following new clause:

''(iii) premiums under section 1859D(d).'';

(2) in subparagraph (B), by inserting ''and section 1859D(c)(3)(B) and 1859D(c)(3)(C)(i)'' after ''1813''; and

(3) in subparagraph (C), by striking ''and section 1833(b)'' and inserting '', section 1833(b), and section 1859D(c)(2)''.

(b) EXPANDED SLMB ELIGIBILITY.—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) by adding ''and'' at the end of clause (iv); and

(3) by adding at the end the following new clause:

''(v)(I) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) and section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries) who are enrolled under part D of title XVIII and are described in section 1905(p)(1)(B) or would be so described but for the fact that their income exceeds 100 percent, but is less than 150 percent, of the official poverty line (referred to in such section) for a family of the size involved;

''(II) subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries and individuals described in subclause (I)) who are enrolled under part D of title XVIII and would be described in section 1905(p)(1)(B) but for the fact that their income exceeds 150 percent, but is less than 175 percent, of the official poverty line (referred to in such section) for a family of the size involved, for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) and section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, and the assistance for medicare cost-sharing described in section 1905(p)(3)(A)(iii) is reduced (on a sliding scale based on income) from 100 percent to 0 percent as the income increases from 150 percent to 175 percent of such poverty line;''.

(c) FEDERAL FINANCING.—The third sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting before the period at the end the following: ''and with respect to amounts expended that are attributable to section 1902(a)(10)(E)(v) (other than for individuals described in section 1905(p)(1)(B))''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(A) by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively; and

(B) by inserting after paragraph (4) the following new paragraph:

''(5)(A) In the case of a State, other than the 50 States and the District of Columbia—

''(i) the provisions of paragraph (3) insofar as they relate to section 1859D and the provisions of section 1902(a)(10)(E)(v) shall not apply to residents of such State; and

''(ii) if the State establishes a plan described in subparagraph (B) (for providing medical assistance with respect to the provision of prescription medicines to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in subparagraph (C).

''(B) The plan described in this subparagraph is a plan that—

''(i) provides medical assistance with respect to the provision of covered outpatient medicines (as defined in section 1859D(b)) to low-income medicare beneficiaries; and

''(ii) assures that additional amounts received by the State that are attributable to the operation of this paragraph are used only for such assistance.

''(C)(i) The amount specified in this subparagraph for a State for a year is equal to the product of—

''(I) the aggregate amount specified in clause (ii); and

''(II) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(ii) The aggregate amount specified in this clause for—

''(I) 2006, is equal to $25,000,000; or

''(II) a subsequent year, is equal to the aggregate amount specified in this clause for the previous year increased by annual percentage increase specified in section 1859D(c)(8)(B) for the year involved.

''(D) The Secretary shall submit to Congress a report on the application of this paragraph and may include in the report such recommendations as the Secretary deems appropriate.''.

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1905(p)(5)(A)(ii)'' after ''Subject to subsection (g)''.

(e) APPLICATION OF COST-SHARING.—Section 1902(n)(2) (42 U.S.C. 1396a(n)(2)) is amended by adding at the end the following: ''The previous sentence shall not apply to medicare cost-sharing relating to benefits under part D of title XVIII.''.

(f) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for premiums and cost-sharing incurred on or after January 1, 2006, with regard to whether regulations to implement such amendments are promulgated by such date.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription medicine benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2004.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) PRESCRIPTION MEDICINE BENEFIT PROGRAM.—Specifically, the Commission shall review, with respect to the prescription medicine benefit program under part D, the following:

''(i) The methodologies used for the management of costs and utilization of prescription medicines.

''(ii) The prices negotiated and paid, including trends in such prices and applicable discounts and comparisons with prices under section 1859E(a)(2)(E).

''(iii) The relationship of pharmacy acquisition costs to the prices so negotiated and paid.

''(iv) The methodologies used to ensure access to covered outpatient prescription medicines and to ensure quality in the appropriate dispensing and utilization of such medicines.

''(v) The impact of the program on promoting the development of breakthrough medicines.''.

SEC. 106. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established, as of the first day of the third month beginning after the date of the enactment of this Act, a State Pharmaceutical Assistance Transition Commission (in this section referred to as the ''Commission'') to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the medicare prescription drug program under part D of title XVIII of the Social Security Act.

(2) DEFINITIONS.—For purposes of this section:

(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term ''State pharmaceutical assistance program'' means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act assistance to low-income medicare beneficiaries for the purchase of prescription drugs.

(B) PROGRAM PARTICIPANT.—The term ''program participant'' means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(b) COMPOSITION.—The Commission shall include the following:

(1) A representative of each governor of each State that the Secretary identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under part D of title XVIII of the Social Security Act.

(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

(4) Representatives of Medicare+Choice organizations and other private health insurance plans, as appointed by the Secretary.

(5) The Secretary (or the Secretary's designee) and such other members as the Secretary may specify.

The Secretary shall designate a member to serve as chair of the Commission and the Commission shall meet at the call of the chair.

(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

(2) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this title.

(3) Principles of medicare modernization provided under title II of this Act.

(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and the Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

TITLE II—MEDICARE+CHOICE

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERVICE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by adding at the end the following:

''(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

''(i) IN GENERAL.—For 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

''(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.''.

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''.

(b) REVISION OF BLEND.—

(1) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting ''who (with respect to determinations for 2004) are enrolled in a Medicare+Choice plan'' after ''the average number of medicare beneficiaries''.

(2) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1)(A), by inserting ''(for a year before 2004)'' after ''multiplied''; and

(B) in paragraph (5), by inserting ''(before 2004)'' after ''for each year''.

(c) INCREASING MINIMUM PERCENTAGE INCREASE TO NATIONAL GROWTH RATE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended—

(A) in subparagraph (B)(iv), by striking ''and each succeeding year'' and inserting '', 2003, and 2004'';

(B) in subparagraph (C)(iv), by striking ''and each succeeding year'' and inserting ''and 2003''; and

(C) by adding at the end of subparagraph (C) the following new clause:

''(v) For 2004 and each succeeding year, the greater of—

''(I) 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year; or

''(II) the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.''.

(2) CONFORMING AMENDMENT.—Section 1853(c)(6)(C) (42 U.S.C. 1395w–23(c)(6)(C)) is amended by inserting before the period at the end the following: '', except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004''.

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-

ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)'', and

(2) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(e) EXTENDING SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS TO REHABILITATION HOSPITALS.—

(1) IN GENERAL.—Section 1853(g) (42 U.S.C. 1395w–23(g)) is amended—

(A) by inserting ''or from a rehabilitation facility (as defined in section 1886(j)(1)(A))'' after ''1886(d)(1)(B))''; and

(B) in paragraph (2)(B), by inserting ''or section 1886(j), as the case may be,'' after ''1886(d)''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contract years beginning on or after January 1, 2004.

(f) MEDPAC STUDY OF AAPCC.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) as applied under section 1853(c)(1)(A) of such Act (as amended by subsection (a)). Such study shall include an examination of—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment under the Medicare+Choice program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

(g) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE+CHOICE PLANS.—Not later than July 1, 2006, the Medicare Benefits Administrator shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and BIPA) on the availability of Medicare+Choice plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(h) LIMITATION ON APPLICATION TO 2004 AND 2005.—Notwithstanding any other provision of law, the amendments made by this section shall only apply to payment rates for 2004 and 2005 and for subsequent years the payment shall be made on the basis of law as in effect before the date of the enactment of this Act.

SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE+CHOICE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD.

(a) CHANGE IN REPORTING DEADLINE.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by section 532(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ''2002, 2003, and 2004 (or July 1 of each other year)'' and inserting ''2002 and each subsequent year''.

(b) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking ''and after 2005''; and

(2) by striking '', 2004, and 2005'' and inserting ''and any subsequent year''.

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking ''and after 2005''; and

(2) by striking ''and 2005'' and inserting ''and each subsequent year''.

SEC. 203. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: ''Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.''.

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraph:

''(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

''(i) is institutionalized (as defined by the Secretary);

''(ii) is entitled to medical assistance under a State plan under title XIX; or

''(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.''.

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

''(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.''.

(d) REPORT TO CONGRESS.—Not later than December 31, 2005, the Medicare Benefits Administrator shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect upon the date of the enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 204. MEDICARE MSAS.

Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting ''or with an organization offering a MSA plan'' after ''section 1851(a)(2)(A)''.

SEC. 205. EXTENSION OF REASONABLE COST CONTRACTS.

Subparagraph (C) of section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is amended to read as follows:

''(C)(i) Subject to clause (ii), may be extended or renewed under this subsection indefinitely.

''(ii) For any period beginning on or after January 1, 2008, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area, during the entire previous year, was within the service area of 2 or more plans which were coordinated care Medicare+Choice plans under part C or 2 or more enhanced fee-for-service plans under part E and each of which plan for that previous year for the area involved meets the following minimum enrollment requirements:

''(I) With respect to any portion of the area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area, 5,000 individuals.

''(II) With respect to any other portion of such area, 1,500 individuals.''.

SEC. 206. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking ''December 31, 2004, but only with respect to'' and all that follows and inserting ''December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.''.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

SEC. 301. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot

reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SEC. 302. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w–3) is amended to read as follows:

''COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

''SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS.—

''(1) IMPLEMENTATION OF PROGRAMS.—

''(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

''(B) PHASED-IN IMPLEMENTATION.—The programs shall be phased-in—

''(i) among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

''(I) at least ⅓ of such areas in 2009; and

''(II) at least ⅔ of such areas in 2010; and

''(ii) among items and services in a manner such that the programs apply to the highest cost and highest volume items and services first.

''(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

''(2) ITEMS AND SERVICES DESCRIBED.—The items and services referred to in paragraph (1) are the following:

''(A) DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), including items used in infusion and drugs and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

''(B) OTHER EQUIPMENT AND SUPPLIES.—Items, equipment, and supplies (as described in section 1842(s)(2)(D) other than enteral nutrients).

''(C) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

''(3) EXCEPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

''(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

''(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

''(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF DURABLE MEDICAL EQUIPMENT.—In the case of a covered item for which payment is made on a rental basis under section 1834(a), the Secretary shall establish a process by which rental agreements for the covered items entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1834(a).

''(5) PHYSICIAN AUTHORIZATION.—The Secretary may establish a process under which a physician may prescribe a particular brand or mode of delivery of an item or service if the item or service involved is clinically more appropriate than other similar items or services.

''(6) APPLICATION.—For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1834(a).

''(b) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—

''(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

''(i) The entity meets quality and financial standards specified by the Secretary or developed by the Program Advisory and Oversight Committee established under subsection (c).

''(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

''(iii) Beneficiary access to a choice of multiple suppliers in the area is maintained.

''(iv) Beneficiary liability is limited to 20 percent of the applicable contract award price, except in such cases where a supplier has furnished an upgraded item and has executed an advanced beneficiary notice.

''(B) DEVELOPMENT OF QUALITY STANDARDS FOR DME PRODUCTS.—

''(i) IN GENERAL.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. Not later than July 1, 2007, the Secretary shall establish new quality standards for products subject to competitive acquisition under this section. Such standards shall be applied prospectively and shall be published on the website of the Department of Health and Human Services.

''(ii) CONSULTATION WITH PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—The Secretary shall consult with the Program Advisory and Oversight Committee (established under subsection (c)) to review (and advise the Secretary concerning) the quality standards referred to in clause (i).

''(3) CONTENTS OF CONTRACT.—

''(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(B) TERM OF CONTRACTS.—The Secretary shall recompete contracts under this section not less often than once every 3 years.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—

''(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

''(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

''(5) PAYMENT.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on the bids submitted and accepted under this section for such items and services.

''(6) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

''(A) the contractor has submitted a bid for such items and services under this section; and

''(B) the Secretary has awarded a contract to the contractor for such items and services under this section.

In this section, the term 'bid' means a request for a proposal for an item or service that includes the cost of the item or service, and where appropriate, any services that are attendant to the provision of the item or service.

''(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary shall consider the similarity of the clinical efficiency and value of specific codes and products, including products that may provide a therapeutic advantage to beneficiaries, before delineating the categories and products that will be subject to bidding.

''(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries and monitoring quality of services with respect to the program.

''(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

''(1) ESTABLISHMENT.—There is established a Program Advisory and Oversight Committee (hereinafter in this section referred to as the 'Committee').

''(2) MEMBERSHIP; TERMS.—The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

''(3) DUTIES.—

''(A) TECHNICAL ASSISTANCE.—The Committee shall provide advice and technical assistance to the Secretary with respect to the following functions:

''(i) The implementation of the program under this section.

''(ii) The establishment of requirements for collection of data.

''(iii) The development of proposals for efficient interaction among manufacturers and distributors of the items and services and providers and beneficiaries.

''(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

''(4) INAPPLICABILITY OF FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

''(d) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in beneficiary cost-sharing, access to and quality of items and services, and beneficiary satisfaction.

''(e) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

''(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

''(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

''(B) which are furnished by entities that did not have a face-to-face encounter with the individual.

''(2) TERMS AND CONDITIONS.—Such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2).

''(3) REPORT.—The Secretary shall submit to Congress—

''(A) an initial report on the project not later than December 31, 2008; and

''(B) such progress and final reports on the project after such date as the Secretary determines appropriate.''.

(b) CONFORMING AMENDMENTS.—

(1) DURABLE MEDICAL EQUIPMENT; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(A) in paragraph (1)(B), by striking ''The payment basis'' and inserting ''Subject to subparagraph (E)(i), the payment basis'';

(B) in paragraph (1)(C), by striking ''This subsection'' and inserting ''Subject to subparagraph (E)(ii), this subsection'';

(C) by adding at the end of paragraph (1) the following new subparagraph:

''(E) APPLICATION OF COMPETITIVE ACQUISITION; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of covered items and services that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

''(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

''(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied.''; and

(D) in paragraph (10)(B), by inserting ''in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(E)'' after ''under this subsection''.

(2) OFF-THE-SHELF ORTHOTICS; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(h) (42 U.S.C. 1395m(h)) is amended—

(A) in paragraph (1)(B), by striking ''and (E)'' and inserting '', (E) , and (H)(i)'';

(B) in paragraph (1)(D), by striking ''This subsection'' and inserting ''Subject to subparagraph (H)(ii), this subsection'';

(C) by adding at the end of paragraph (1) the following new subparagraph:

''(H) APPLICATION OF COMPETITIVE ACQUISITION TO ORTHOTICS; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of orthotics described in paragraph (2)(B) of section 1847(a) that are included in a competitive acquisition program in a competitive acquisition area under such section—

''(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

''(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.''.

(c) REPORT ON ACTIVITIES OF SUPPLIERS.—The Secretary shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act, as amended by subsection (a), are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability.

SEC. 303. REFORM OF PAYMENT FOR DRUGS AND BIOLOGICALS UNDER THE MEDICARE PROGRAM.

(a) PAYMENT REFORM.—

(1) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended to read as follows:

''(o) PAYMENT FOR DRUGS AND BIOLOGICALS.—

''(1) GENERAL RULE.—If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological shall be based on the following:

''(A) MULTI-SOURCE (GENERIC) DRUGS.—In the case of a drug or biological that meets the requirements for a multi-source drug under subclauses (I) and (II) of section 1927(k)(7)(A)(i), 105 percent of the volume-weighted median average acquisition price for any drug or biological covered under the same medicare HCPCS code.

''(B) SINGLE SOURCE (BRAND) DRUGS AND BIOLOGICALS.—In the case of a drug or biological that meets the requirements for a single source drug under section 1927(k)(7)(A)(iv), 105 percent of the average acquisition price for the drug or biological.

''(C) ACCESS EXCEPTION.—The Secretary may modify the rate otherwise applicable in order to assure access to necessary drugs and biologicals in the case of sole community providers in rural and other areas where the providers are not reasonably able to obtain the drugs and biologicals at the payment rates otherwise applicable. Such modification shall not result in a change of more than 15 percent of the rate otherwise applicable.

''(D) DATA-RELATED EXCEPTION.—If the Secretary determines that there is insufficient data available with respect to compute an average acquisition price for a drug or biological for a quarter or that, because of a significant change in price from quarter-to-quarter, the available data on the average acquisition price does not accurately reflect the actual, current acquisition cost for the drug or biological, the Secretary may substitute for the quarters involved an appropriate payment for the drug or biological for such average acquisition price.

''(E) APPLICATION OF NDC CODES.—If the Secretary determines that it is appropriate to provide for payment under this subsection using national drug code (NDC) instead of HCPCS codes, in applying subparagraph (A) the reference to the same HCPCS code shall be deemed a reference to the appropriate national drug codes for those drugs or biologicals that are therapeutically and pharmaceutically equivalent and bioequivalent (as defined for purposes of section 1927(k)(7)(A)).

''(2) DEFINITION OF AVERAGE ACQUISITION PRICE.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'average acquisition price' means, with respect to a drug or biological and with respect to each dosage form and strength of the drug or biological product (without regard to any special packaging, labeling, or identifiers on the dosage form or

product or package), the average of all final sales prices charged by the manufacturer of the drug or biological product in the United States, excluding sales exempt from inclusion in the calculation of best price under section 1927(c)(1)(C) (other than under clause (ii)(III) of such section) and excluding sales subject to a rebate under section 1927, as reported under paragraph (3).

''(B) NET PRICE.—Such average acquisition price shall be calculated net of all of the following (as estimated by the Secretary):

''(i) Volume discounts.

''(ii) Prompt pay discounts and cash discounts.

''(iii) Charge-backs.

''(iv) Short-dated product discounts (for spoilage and other factors).

''(v) Free goods and services.

''(vi) Rebates.

''(vii) All other price concessions provided by the drug manufacturer.

The Secretary may make subsequent adjustments in such average acquisition price to take into account updated information and differences between the price previously estimated and the actual average acquisition price.

''(C) WEIGHTING.—The average of all final sales prices described in subparagraph (A) shall be determined by dividing—

''(i) the sum of all final prices charged by the manufacturer (net of the adjustments made under subparagraph (B)) for sales in the period involved that are included in subparagraph (A) for the drug or biological, by

''(ii) the total number of units of such sales in the period.

''(D) DISTRIBUTION OF REPORTS.—The Secretary shall promptly distribute applicable payment rates under this subsection to carriers and fiscal intermediaries and other contractors that make payment for drugs and biologicals under this section in order to apply a uniform reimbursement rate under this section.

''(3) PRICE REPORTING REQUIREMENT.—

''(A) IN GENERAL.—As a condition for payment for any drug or biological of a manufacturer under this subsection, the manufacturer of the drug or biological shall—

''(i) report, on a quarterly basis, to the Secretary (or the Secretary's designee) the manufacturer's average acquisition price and the information required under subparagraph (C) for all drugs and biologicals of the manufacturer by national drug code (NDC);

''(ii) maintain such records (in written or electronic form) regarding such sales and prices for all such drugs and biologicals as may be necessary to audit the information so reported or required to be reported; and

''(iii) provide the Secretary with access to such records in order to permit the Secretary to audit information so reported or required to be reported.

''(B) PENALTIES.—The provisions of section 1927(b)(3)(C) shall apply with respect to the reporting of information under subparagraph (A) in the same manner as it applies to the reporting of information under section 1927(b)(3)(A), except that the reference in clause (i) of such section to $10,000 is deemed a reference to $100,000 and any reference to a suspension of an agreement is deemed a reference to a suspension of payment for the drug or biological involved under this part. The Secretary shall promptly refer to the Inspector General of the Department of Health and Human Services and, if appropriate, to appropriate officials in the Department of Justice cases in which the Secretary becomes aware of a false price representation made in the information submitted under this paragraph.

''(C) FORM OF REPORTING.—Information required to be reported under subparagraph (A)(i) shall be reported in a form and manner specified by the Secretary. The information required to be reported shall include the identification of the generic name of the drug or biological and its brand name (if any), the national drug code (NDC) and the HCPCS code assigned to the drug or biological, the dosage form, strength, volume, and package size involved. The information for a quarter shall be submitted not later than 30 days after the end of the quarter. The information shall be accompanied by a written and signed certification by an officer of the manufacturer attesting to the accuracy of the information reported. Such information shall include updated information on the net price realized (taking into account rebates and other amounts affecting net price), regardless of the period for which such a rebate or other adjustment in net price might have been earned.

''(D) AUDITING.—The Secretary shall audit on a periodic basis information reported or required to be reported under this paragraph. The Secretary may conduct such independent price gathering activities, such as surveys and review of published catalog information or other transactional information, as may be appropriate to verify the accuracy of the information reported.

''(4) DISPENSING FEE.—If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary shall pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy. Such a dispensing fee shall be subject to adjustment from year to year based upon changes in the consumer price index over time and may be adjusted as the Secretary determines to be appropriate to reflect differences in the costs of dispensing different drugs and biologicals.

''(5) PAYMENT REQUIRED ON AN ASSIGNMENT-RELATED BASIS.—

''(A) IN GENERAL.—Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment-related basis.

''(B) APPLICATION OF ENFORCEMENT PROVISIONS.—The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to services furnished by a practitioner described in subsection (b)(18)(C).''.

(2) EFFECTIVE DATE.—Subject to subsection (i)(2), the amendment made by paragraph (1) shall apply to drugs and biologicals furnished on or after January 1, 2004.

(b) MEDICARE PAYMENT FOR DRUG ADMINISTRATION SERVICES.—

(1) IN GENERAL.—The Secretary shall revise the practice expense relative value units for drug administration services for years beginning with the year 2005 in accordance with this subsection. For purposes of this subsection, the term ''drug administration services'' includes chemotherapy administration services, therapeutic and diagnostic infusions and injections, and such other services as the Secretary specifies.

(2) DIRECT COSTS EQUAL TO 100 PERCENT OF CPEP ESTIMATES.—Using the information, including estimates of clinical staff time, developed in the clinical practice expert panel process, including refinements by American Medical Association committees, the Secretary shall estimate the costs of the nursing and other clinical staff, supplies, and procedure-specific equipment (exceeding a cost specified by the Secretary) used in furnishing each type of drug administration service. The Secretary shall utilize without revision the minutes of clinical staff time determined in such process. The Secretary shall convert the information from such process to estimated costs by applying the most current available data on staff salary, supply, and equipment costs, and such costs shall be updated to 2005 based on estimated changes in prices since the date of such data.

(3) TOTAL PRACTICE EXPENSES.—The Secretary shall estimate the total practice expenses of each drug administration service by assuming that the direct costs for the service determined under paragraph (3) are 33.2 percent of such total practice expenses.

(4) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under paragraph (3) to practice expense relative value units for each drug administration service by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(5) UPDATES.—For years after 2005, the relative values determined under paragraph (4) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this subsection.

(6) MULTIPLE PUSHES.—In establishing the payment amounts under this subsection, the Secretary shall establish the payment amount for intravenous chemotherapy administration by push technique based on the administration of a single drug. The Secretary shall make the same payment for each additional drug administered by push technique during the same encounter, except to the extent that the Secretary finds that the cost of administering additional drugs is less than the cost of administering the first drug.

(c) PAYMENTS FOR CHEMOTHERAPY SUPPORT SERVICES.—

(1) GENERAL.—Beginning in 2005, the Secretary shall recognize and make payments under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for chemotherapy support services furnished incident to physicians' services. For the purposes of this section, the term ''chemotherapy support services'' are services furnished by the staff of physicians to patients undergoing treatment for cancer that were not included in the computation of clinical staff costs under subsection b(2). Such services include social worker services, nutrition counseling, psychosocial services, and similar services.

(2) DIRECT COSTS.—The Secretary shall estimate the cost of the salary and benefits of staff furnishing chemotherapy support services as they are provided in oncology practices that furnish these services to cancer patients in a manner that is considered to be high quality care. The estimate shall be based on the weekly cost of such services per patient receiving chemotherapy.

(3) TOTAL COSTS.—The Secretary shall estimate the total practice expenses of chemotherapy support services by assuming that the direct costs for the service determined under paragraph (2) are 33.2 percent of such total practice expenses.

(4) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under paragraph (3) to practice expense relative value units for chemotherapy support services by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for chemotherapy support services under such section 1848.

(5) UPDATES.—For years after 2005, the relative values determined under paragraph (4) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such

revisions are consistent with the methodology set forth in this subsection.

(d) CANCER THERAPY MANAGEMENT SERVICES.—Beginning in 2005, the Secretary shall recognize and establish a payment amount for the service of cancer therapy management to account for the greater pre-service and post-service work associated with visits and consultations conducted by physicians treating cancer patients compared to typical visits and consultations. The payment amount may vary by the level and type of the related visit or consultation.

(e) OTHER SERVICES WITHOUT PHYSICIAN WORK RELATIVE VALUE UNITS.—Beginning in 2005, the Secretary shall develop a revised methodology for determining the payment amounts for services that are paid under the fee schedule established by section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and that do not have physician work relative value units, including radiation oncology services. Such methodology shall result in payment amounts that fully cover the costs of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of any one specialty's services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

(f) REPORT TO CONGRESS.—Not later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that are projected to be adopted under subsections (b), (c), (d), and (e) of this section.

(g) INSTITUTE OF MEDICINE STUDY.—

(1) GENERAL.—The Secretary shall request the Institute of Medicine to conduct the study described in this subsection.

(2) BASELINE STUDY.—The first phase of the study shall include the following objectives:

(A) An assessment of the extent to which the current medicare payment system, prior to implementation of the amendments made by this section, facilitates appropriate access to care by cancer patients in the various treatment settings.

(B) The identification of the comprehensive range of services furnished to cancer patients in the outpatient setting, including support services such as psychosocial services and counseling, and recommendations regarding the types of services that ought to be furnished to medicare patients with cancer.

(C) A discussion of the practice standards necessary to assure the safe provision of services to cancer patients.

(D) An analysis of the extent to which the current medicare payment system supports the role of nurses in the provision of oncology services and recommendations for any necessary improvements in the payment system in that respect.

(E) The development of a framework for assessing how the amendments made by this act affect the provision of care to medicare patients with cancer in the various treatment settings.

(3) SECOND PHASE OF STUDY.—After the implementation of the amendments made by this section, the study shall determine whether and how those amendments affected the provision of care to medicare patients with cancer.

(4) CONSULTATION.—The Institute of Medicine shall consult with the National Cancer Policy Board and organizations representing cancer patients and survivors, oncologists, oncology nurses, social workers, cancer centers, and other healthcare professionals who treat cancer patients in planning and carrying out this study.

(5) DUE DATES.—

(A) The study required by paragraph (2) shall be submitted to the Congress and the Secretary of Health and Human Services no later than June 30, 2004.

(B) The study required by paragraph (3) shall be submitted to the Congress and the Secretary of Health and Human Services no later than December 31, 2006.

(i) STUDY OF PAYMENTS FOR BLOOD CLOTTING FACTORS AND OTHER BIOLOGICALS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide for a study of the appropriateness of the medicare payment methodology for blood clotting factors and other biologicals under part B of title XVIII of the Social Security Act. Not later than 9 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on such study and shall include in such report recommendations regarding whether to apply the payment methodology provided under the amendment made by subsection (a)(1) and alternative recommendations for appropriate dispensing fees.

(2) DELAY IN EFFECTIVE DATE.—The amendment made by subsection (a)(1) shall not apply to blood clotting factors furnished before the first day of the first calendar year that begins at least 6 months after the date the report under paragraph (1) has been submitted to the Congress.

SEC. 304. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A or part B of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—

(1) SCOPE.—The project shall cover at least 2 States that are among the States with—

(A) the highest per capita utilization rates of medicare services, and

(B) at least 3 contractors.

(2) DURATION.—The project shall last for not longer than 3 years.

(c) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency in recovery audits with private insurers or under the medicaid program under title XIX of such Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

SEC. 401. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting '', and, after October 1, 2004, for any other hospital described in clause (iv),'' after ''clause (iv)(I)'' in the matter preceding subclause (I).

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xiii)'';

(ii) in subclause (III)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xii)'';

(iii) in subclause (IV)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x) or (xi)'';

(iv) in subclause (V)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xi)''; and

(v) in subclause (VI)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x)'';

(B) in clause (viii), by striking ''The formula'' and inserting ''For discharges occurring before October 1, 2004, the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''With respect to discharges occurring before October 1, 2004, for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2004.

SEC. 402. IMMEDIATE ESTABLISHMENT OF UNIFORM STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS.

(a) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

(1) in clause (iv), by inserting ''and ending on or before September 30, 2003,'' after ''October 1, 1995,''; and

(2) by redesignating clauses (v) and (vi) as clauses (vii) and (viii), respectively, and inserting after clause (iv) the following new clauses:

''(v) For discharges occurring in the fiscal year beginning on October 1, 2003, the average standardized amount for hospitals located in areas other than a large urban area shall be equal to the average standardized amount for hospitals located in a large urban area.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new clause:

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

SEC. 403. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

(a) CLASSIFICATION.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended—

(1) in the heading by adding ''ESSENTIAL RURAL HOSPITALS'' at the end; and

(2) by adding at the end the following new paragraphs:

''(4)(A) The term 'essential rural hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is located in a rural area (as defined for purposes of section 1886(d)), has more than 25 licensed acute care inpatient beds, has applied to the Secretary for classification as such a hospital, and with respect to which the Secretary has determined that the closure of the hospital would significantly diminish the ability of medicare beneficiaries to obtain essential health care services.

''(B) The determination under subparagraph (A) shall be based on the following criteria:

''(i) HIGH PROPORTION OF MEDICARE BENEFICIARIES RECEIVING CARE FROM HOSPITAL.—(I) A high percentage of such beneficiaries residing in the area of the hospital who are hospitalized (during the most recent year for which complete data are available) receive basic inpatient medical care at the hospital.

''(II) For a hospital with more than 200 licensed beds, a high percentage of such beneficiaries residing in such area who are hospitalized (during such recent year) receive specialized surgical inpatient care at the hospital.

''(III) Almost all physicians described in section 1861(r)(1) in such area have privileges at the hospital and provide their inpatient services primarily at the hospital.

''(ii) SIGNIFICANT ADVERSE IMPACT IN ABSENCE OF HOSPITAL.—If the hospital were to close—

''(I) there would be a significant amount of time needed for residents to reach emergency treatment, resulting in a potential significant harm to beneficiaries with critical illnesses or injuries;

''(II) there would be an inability in the community to stablize emergency cases for transfers to another acute care setting, resulting in a potential for significant harm to medicare beneficiaries; and

''(III) any other nearby hospital lacks the physical and clinical capacity to take over the hospital's typical admissions.

''(C) In making such determination, the Secretary may also consider the following:

''(i) Free-standing ambulatory surgery centers, office-based oncology care, and imaging center services are insufficient in the hospital's area to handle the outpatient care of the hospital.

''(ii) Beneficiaries in nearby areas would be adversely affected if the hospital were to close as the hospital provides specialized knowledge and services to a network of smaller hospitals and critical access hospitals.

''(iii) Medicare beneficiaries would have difficulty in accessing care if the hospital were to close as the hospital provides significant subsidies to support ambulatory care in local clinics, including mental health clinics and to support post acute care.

''(iv) The hospital has a committment to provide graduate medical education in a rural area.

''(C) QUALITY CARE.—The hospital inpatient score for quality of care is not less than the median hospital score for qualify of care for hospitals in the State, as established under standards of the utilization and quality control peer review organization under part B of title XI or other quality standards recognized by the Secretary.

A hospital classified as an essential rural hospital may not change such classification and a hospital so classified shall not be treated as a sole community hospital, medicare dependent hospital, or rural referral center for purposes of section 1886.''.

(b) PAYMENT BASED ON 102 PERCENT OF ALLOWED COSTS.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11) In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for inpatient hospital services for discharges occurring during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this paragraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under part A or as waiving any requirement for billing for such services.''.

(2) HOSPITAL OUTPATIENT SERVICES.—Section 1833(t)(13) (42 U.S.C. 1395l(t)(13)) is amended by adding at the end the following new subparagraph:

''(B) SPECIAL RULE FOR ESSENTIAL RURAL HOSPITALS.—In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for covered OPD services during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this subparagraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under this part or as waiving any requirement for billing for such services.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2004.

SEC. 404. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) REPORT.—Not later than October 1, 2004, the Secretary shall submit a report to Congress on the frequency established under subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l); 1395m(g)(1); 42 U.S.C. 1395tt(a)(3)) are each amended by inserting ''equal to 102 percent of'' before ''the reasonable costs''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after October 1, 2003.

(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting ''CERTAIN'' before ''EMERGENCY''; and

(ii) by striking ''PHYSICIANS'' and inserting ''PROVIDERS'';

(B) by striking ''emergency room physicians who are on-call (as defined by the Secretary)'' and inserting ''physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services''; and

(C) by striking ''physicians' services'' and inserting ''services covered under this title''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to costs incurred for services provided on or after January 1, 2004.

(c) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as follows:

''(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;''.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking ''and the number of beds used at any time for acute care inpatient services does not exceed 15 beds''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2004.

(d) ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) ELIMINATION.—

(A) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2005.

(2) TECHNICAL CORRECTION.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9).

(e) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting '', in the cases described in subparagraphs (A) through (D)'' after ''1986''; and

(B) by striking ''and'' at the end of subparagraph (C);

(C) by adding ''and'' at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

(2) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

(3) REINSTATEMENT OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after January 1, 2004.

(f) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

''The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective as if included in the enactment of section 403(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–371).

(g) ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR GRANT PROGRAM.—

(1) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraph:

''(4) FUNDING.—

''(A) IN GENERAL.—Subject to subparagraph (B), payment for grants made under this subsection during fiscal years 2004 through 2008 shall be made from the Federal Hospital Insurance Trust Fund.

''(B) ANNUAL AGGREGATE LIMITATION.—In no case may the amount of payment provided for under subparagraph (A) for a fiscal year exceed $25,000,000.''.

(2) CONFORMING AMENDMENT.—Section 1820 (42 U.S.C. 1395i–4) is amended by striking subsection (j).

SEC. 406. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting ''subject to subparagraph (I),'' after ''October 1, 1997,'';

(2) in subparagraph (H)(i), by inserting ''subject to subparagraph (I),'' after ''subparagraphs (F) and (G),''; and

(3) by adding at the end the following new subparagraph:

''(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2004, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

''(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2002.

''(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

''(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2003.

''(V) AFFILIATION.—With respect to hospitals which are members of the same affiliated group (as defined by the Secretary under subparagraph (H)(ii)), the provisions of this section shall be applied with respect to such an affiliated group by deeming the affiliated group to be a single hospital.

''(ii) REDISTRIBUTION.—

''(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

''(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2004, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2005.

''(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

''(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

''(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

''(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

''(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

''(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

''(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.''.

(b) CONFORMING AMENDMENT TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: ''The provisions of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentece of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection.''.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

SEC. 407. TWO-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking ''SMALL'' and inserting ''CERTAIN'';

(B) by inserting ''or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area'' after ''100 beds''; and

(C) by striking ''2004'' and inserting ''2006''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply with respect to payment for OPD services furnished on and after January 1, 2004.

(b) STUDY; ADJUSTMENT.—

(1) STUDY.—The Secretary shall conduct a study to determine if, under the prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), costs incurred by rural providers of services by ambulatory payment classification groups (APCs) exceed those costs incurred by urban providers of services.

(2) ADJUSTMENT.—Insofar as the Secretary determines under paragraph (1) that costs incurred by rural providers exceed those costs incurred by urban providers of services, the Secretary shall provide for an appropriate adjustment under such section 1833(t) to reflect those higher costs by January 1, 2005.

SEC. 408. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C. 1395yy(e)(2)(A)) is amended—

(1) in clause (i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii), (iii), and (iv)''; and

(2) by adding at the end the following new clause:

''(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

''(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

''(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were not furnished by an individual affiliated with a rural health clinic or a Federally qualified health center.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2004.

SEC. 409. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting ''or nurse practitioner (as defined in subsection (aa)(5))'' after ''the physician (as defined in subsection (r)(1))''.

(b) PROHIBITION ON NURSE PRACTITIONER CERTIFYING NEED FOR HOSPICE.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting ''(which for purposes of this subparagraph does not include a nurse practitioner)'' after ''attending physician (as defined in section 1861(dd)(3)(B))''.

SEC. 410. IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9); and

(2) by adding at the end the following new paragraph:

''(10) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW MEDICARE POPULATION DENSITY AREAS.—

''(A) IN GENERAL.—In the case of ground ambulance services furnished on or after January 1, 2004, for which the transportation originates in a qualified rural area (as defined in subparagraph (B)), the Secretary shall provide for an increase in the base rate of the fee schedule for mileage for a trip established under this subsection. In establishing such increase, the Secretary shall, based on the relationship of cost and volume, estimate the average increase in cost per trip for such services as compared with the cost per trip for the average ambulance service.

''(B) QUALIFIED RURAL AREA DEFINED.—For purposes of subparagraph (A), the term 'qualified rural area' is a rural area (as defined in section 1886(d)(2)(D)) with a population density of medicare beneficiaries residing in the area that is in the lowest three quartiles of all rural county populations.''.

SEC. 411. TWO-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) during 2004 and 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(G) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.''.

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(G) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) INTERIM FINAL EFFECT.—No later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 413. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions; and

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 414. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

''(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 415. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking ''4-year'' and inserting ''8-year''; and

(2) in subsection (d)(3), by striking ''$30,000,000'' and inserting ''$60,000,000''.

SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking ''WAGE LEVELS.—The Secretary'' and inserting ''WAGE LEVELS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary''; and

(2) by adding at the end the following new clause:

''(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2004.—

''(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2003, the Secretary shall substitute the '62 percent' for the proportion described in the first sentence of clause (i).

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Medicare Prescription Drug and Modernization Act of 2003 had not been enacted.''.

SEC. 417. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) ADDITIONAL BONUS PAYMENT FOR CERTAIN PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 1395*l*) is amended by adding at the end the following new subsection:

''(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

''(1) IN GENERAL.—In the case of physicians' services furnished in a year—

''(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

''(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

''(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall periodically determine, for each county or equivalent area in the United States, the following:

''(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

''(i) primary care physicians; or

''(ii) physicians who are not primary care physicians.

''(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both.

''(C) DETERMINATION OF RATIOS.—

''(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the 'primary care ratio') of the number of primary care physicians (determined under subparagraph (A)(i)), to number of medicare beneficiaries determined under subparagraph (B).

''(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the 'specialist care ratio') of the number of other physicians (determined under subparagraph (A)(ii)), to number of medicare beneficiaries determined under subparagraph (B).

''(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

''(4) IDENTIFICATION OF COUNTIES.—The Secretary shall identify—

''(A) those counties and areas (in this paragraph referred to as 'primary care scarcity counties') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph; and

''(B) those counties and areas (in this subsection referred to as 'specialist care scarcity counties') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph.

There is no administrative or judicial review respecting the identification of a county or area or the assignment of a specialty of any physician under this paragraph.

''(5) RURAL CENSUS TRACKS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

''(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term 'physician' means a physician described in section 1861(r)(1) and the term 'primary care physician' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

''(7) PUBLICATION OF LIST OF COUNTIES.—In carrying out this subsection for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a primary care scarcity county or specialist care scarcity county under this subsection for the year involved.''.

(2) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to physicians' services furnished or after January 1, 2004.

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(A) by inserting ''(1)'' after ''(m)''; and

(B) by adding at the end the following new paragraphs:

''(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).

''(3) In carrying out paragraph (1) for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a health professional shortage area under paragraph (1) for the year involved.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to physicians' services furnished or after January 1, 2004.

SEC. 418. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

''(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

''(A) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

''(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

''(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

''(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph; and

''(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

''(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term 'low-volume hospital' means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

''(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

''(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

''(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).''.

SEC. 419. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2004 or 2005 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) NO BENEFICIARY COST-SHARING.—Notwithstanding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 420. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraphs (B) and (C)'' and inserting ''subparagraphs (B), (C), (E), and (F)''; and

(2) by adding at the end the following new subparagraphs:

''(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

''(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

''(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term 'applicable floor index' means—

''(I) 0.980 with respect to services furnished during 2004; and

''(II) 1.000 for services furnished during 2005, 2006, and 2007.

''(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 421. AMBULANCE PAYMENT RATES.

(a) PAYMENT RATES.—Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is amended to read as follows:

''(3) PAYMENT RATES.—

''(A) IN GENERAL.—Subject to any adjustment under subparagraph (B) and paragraph (9) and the full payment of a national mileage rate pursuant to subparagraph (2)(E), in establishing such fee schedule, the following rules shall apply:

''(i) PAYMENT RATES IN 2003.—

''(I) GROUND AMBULANCE SERVICES.—In the case of ground ambulance services furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services at a rate based on the average costs (as determined by the Secretary on the basis of the most recent and reliable information available) incurred by full cost ambulance suppliers in providing nonemergency basic life support ambulance services covered under this title, with adjustments to the rates for other ground ambulance service levels to be determined based on the rule established under paragraph (1). For the purposes of the preceding sentence, the term 'full cost ambulance supplier' means a supplier for which volunteers or other unpaid staff comprise less than 20 percent of the supplier's total staff and which receives less than 20 percent of space and other capital assets free of charge.

''(II) OTHER AMBULANCE SERVICES.—In the case of ambulance services not described in subclause (I) that are furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services based on the rule established under paragraph (1).

''(ii) PAYMENT RATES IN SUBSEQUENT YEARS FOR ALL AMBULANCE SERVICES.—In the case of any ambulance service furnished under this part in 2004 or any subsequent year, the Secretary shall set the payment rates under the fee schedule for such service at amounts equal to the payment rate under the fee schedule for that service furnished during the previous year, increased by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year.

''(B) ADJUSTMENT IN RURAL RATES.—For years beginning with 2004, the Secretary, after taking into consideration the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall adjust the fee schedule payment rates that would otherwise apply under this subsection for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.''.

(b) CONFORMING AMENDMENT.—Section 221(c) of BIPA is repealed.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 501. ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME).

Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) by striking ''and'' at the end of subclause (VI);

(2) in subclause (VII)—

(A) by striking ''on or after October 1, 2002,'' and inserting ''during fiscal year 2003,''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by inserting after subclause (VII) the following new subclauses:

''(VIII) during each of fiscal years 2004 and 2005, 'c' is equal to 1.47; and

''(IX) on or after October 1, 2005, 'c' is equal to 1.35.''.

SEC. 502. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

''(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.''.

(b) ELIGIBILITY STANDARD FOR TECHNOLOGY OUTLIERS.—

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

(A) by inserting ''(I)'' after ''(vi)''; and

(B) by adding at the end the following new subclause:

''(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of specific discharges in which the service or technology has been used.''.

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting ''(applying a threshold specified by the Secretary that is 75 percent of one standard deviation for the diagnosis-related group involved)'' after ''is inadequate''.

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following subclause:

''(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority review has been provided under section 515(d)(5) of such Act. Nothing in this subclause shall be construed as effecting the authority of the Secretary to determine whether items and services are medically necessary and appropriate under section 1862(a)(1).''.

(4) PROCESS FOR PUBLIC INPUT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by paragraph (1), is amended—

(A) in clause (i), by adding at the end the following: ''Such mechanism shall be modified to meet the requirements of clause (viii).''; and

(B) by adding at the end the following new clause:

''(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

''(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

''(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

''(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.''.

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further amended by adding at the end the following new clause:

''(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into

a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, the new technology would no longer meet the threshold of exceeding 75 percent of the standard deviation for the diagnosis-related group involved under clause (ii)(I). No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).''.

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after ''the estimated average cost of such service or technology'' the following: ''(based on the marginal rate applied to costs under subparagraph (A))''.

(e) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL INPATIENT TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking ''subject to paragraph (4)(C)(iii),''.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2005.

(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2003 THAT ARE DENIED.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 503. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(B) in clause (ii), by striking ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'' and inserting ''the applicable Federal percentage (specified in subparagraph (E))''; and

(2) by adding at the end the following new subparagraph:

''(E) For purposes of subparagraph (A), for discharges occurring—

''(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

''(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 41 percent and the applicable Federal percentage is 59 percent;

''(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 33 percent and the applicable Federal percentage is 67 percent; and

''(v) on or after October 1, 2005, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.''.

SEC. 504. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM .

(a) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11)(A) In order to recognize commuting patterns among Metropolitan Statistical Areas and between such Areas and rural areas, the Secretary shall establish a process, upon application of a subsection (d) hospital that establishes that it is a qualifying hospital described in subparagraph (B), for an increase of the wage index applied under paragraph (3)(E) for the hospital in the amount computed under subparagraph (D).

''(B) A qualifying hospital described in this subparagraph is a subsection (d) hospital—

''(i) the average wages of which exceed the average wages for the area in which the hospital is located; and

''(ii) which has at least 10 percent of its employees who reside in one or more higher wage index areas.

''(C) For purposes of this paragraph, the term 'higher wage index area' means, with respect to a hospital, an area with a wage index that exceeds that of the area in which the hospital is located.

''(D) The increase in the wage index under subparagraph (A) for a hospital shall be equal to the percentage of the employees of the hospital that resides in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

''(i) the difference between (I) the wage index for such area, and (II) the wage index of the area in which the hospital is located (before the application of this paragraph); and

''(ii) the number of employees of the hospital that reside in such higher wage index area divided by the total number of such employees that reside in all high wage index areas.

''(E) The process under this paragraph shall be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10) with respect to data submitted by hospitals to the Board on the location of residence of hospital employees and wages under the applicable schedule established for geographic reclassification.

''(F) A reclassification under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

''(G) A hospital that is reclassified under this paragraph for a period is not eligible for reclassification under paragraphs (8) or (10) during that period.

''(H) Any increase in a wage index under this paragraph for a hospital shall not be taken into account for purposes of—

''(i) computing the wage index for the area in which the hospital is located or any other area; or

''(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall first apply to the wage index for cost reporting period beginning on or after October 1, 2004.

SEC. 505. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(1) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (A); and

(B) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

''(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and''.

(2) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

''(7) SPECIALTY HOSPITAL.—

''(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

''(i) patients with a cardiac condition;

''(ii) patients with an orthopedic condition;

''(iii) patients receiving a surgical procedure; or

''(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

''(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

''(i) determined by the Secretary—

''(I) to be in operation before June 12, 2003; or

''(II) under development as of such date;

''(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

''(iii) that meets such other requirements as the Secretary may specify.''.

(b) EFFECTIVE DATE.—Subject to subsection (c), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(2), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

Subtitle B—Other Provisions

SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

''(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

''(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.''.

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

(3) by inserting after paragraph (4) the following new paragraph:

''(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

''(A) an evaluation of the individual's need for pain and symptom management;

''(B) counseling the individual with respect to end-of-life issues and care options; and

''(C) advising the individual regarding advanced care planning.''.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.''.

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: ''and services described in section 1812(a)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 601. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2004 AND 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(5) UPDATE FOR 2004 AND 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.''.

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting ''and paragraph (5)'' after ''subparagraph (D)''.

(3) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

(1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—

(A) by striking ''projected'' and inserting ''annual average''; and

(B) by striking ''from the previous applicable period to the applicable period involved'' and inserting ''during the 10-year period ending with the applicable period involved''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2003.

SEC. 602. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSICIANS' SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(B) an examination of changes in the use by beneficiaries of physicians' services over time;

(C) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

(b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

(c) GAO STUDY OF MEDICARE PAYMENT FOR INHALATION THERAPY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the medicare program.

(2) REPORT.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 603. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

(b) VOLUME OF PHYSICIAN SERVICES.—The Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1848(f) of the Social Security Act).

(2) An examination of the relative growth of volume in physician services between medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

(4) An examination of the impact on volume of demographic changes.

(5) An examination of shifts in the site of service of services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have affected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

Subtitle B—Preventive Services

SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(W) an initial preventive physical examination (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Initial Preventive Physical Examination

''(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services (excluding clinical laboratory tests), as determined by the Secretary, consistent with the recommendations of the United States Preventive Services Task Force.''.

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)'', and

(B) by inserting before the period at the end the following: '', and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))''.

(2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in clause (N), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''; and

(B) in clause (O), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''.

(d) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(e) OTHER CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) by striking ''and'' at the end of subparagraph (H);

(B) by striking the semicolon at the end of subparagraph (I) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(J) in the case of an initial preventive physical examination, which is performed

not later than 6 months after the date the individual's first coverage period begins under part B;''; and

(2) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (J)''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only for individuals whose coverage period begins on or after such date.

SEC. 612. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 611(a), is amended—

(1) in subparagraph (V), by striking ''and'' at the end;

(2) in subparagraph (W), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(X) cholesterol and other blood lipid screening tests (as defined in subsection (XX));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 611(b), is amended by adding at the end the following new subsection:

''Cholesterol and Other Blood Lipid Screening Test

''(xx)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

''(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more often than once every 2 years.''.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 611(e), is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the semicolon at the end of subparagraph (J) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1861(xx)(1)), which is performed more frequently than is covered under section 1861(xx)(2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 613. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.

(a) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)), as amended by section 611(c)(1), is amended—

(1) by striking ''and'' before ''(7)''; and

(2) by inserting before the period at the end the following: '', and (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))''.

(b) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are each amended—

(1) by striking ''DEDUCTIBLE AND'' in the heading; and

(2) in subclause (I), by striking ''deductible or'' each place it appears.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services furnished on or after Janaury 1, 2004.

SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography''.

(b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diagnostic mammography performed on or after January 1, 2004, for which payment is made under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4), the Secretary, based on the most recent cost data available, shall provide for an appropriate adjustment in the payment amount for the technical component of the diagnostic mammography.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

Subtitle C—Other Services

SEC. 621. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) PAYMENT FOR DRUGS.—

(1) MODIFICATION OF AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(A) by redesignating paragraph (13) as paragraph (14); and

(B) by inserting after paragraph (12) the following new paragraph:

''(13) DRUG APC PAYMENT RATES.—

''(A) IN GENERAL.—With respect to payment for covered OPD services that includes a specified covered outpatient drug (defined in subparagraph (B)), the amount provided for payment for such drug under the payment system under this subsection for services furnished in—

''(i) 2004, 2005, or 2006, shall in no case—

''(I) exceed 95 percent of the average wholesale price for the drug; or

''(II) be less than the transition percentage (under subparagraph (C)) of the average wholesale price for the drug; or

''(ii) a subsequent year, shall be equal to the average price for the drug for that area and year established under the competitive acquisition program under section 1847A as calculated and applied by the Secretary for purposes of this paragraph.

''(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

''(i) IN GENERAL.—In this paragraph, the term 'specified covered outpatient drug' means, subject to clause (ii), a covered outpatient drug (as defined in 1927(k)(2), that is—

''(I) a radiopharmaceutical; or

''(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

''(ii) EXCEPTION.—Such term does not include—

''(I) a drug for which payment is first made on or after January 1, 2003, under paragraph (6); or

''(II) a drug for a which a temporary HCPCS code has not been assigned.

''(C) TRANSITION TOWARDS HISTORICAL AVERAGE ACQUISITION COST.—The transition percentage under this subparagraph for drugs furnished in a year is determined in accordance with the following table:

For the year—	The transition percentage for— Single source drugs are—	Innovator multiple source drugs are—	Generic drugs are—
2004	83%	81.5%	46%
2005	77%	75%	46%
2006	71%	68%	46%

''(D) PAYMENT FOR NEW DRUGS UNTIL TEMPORARY HCPCS CODE ASSIGNED.—With respect to payment for covered OPD services that includes a covered outpatient drug (as defined in 1927(k)) for a which a temporary HCPCS code has not been assigned, the amount provided for payment for such drug under the payment system under this subsection shall be equal to 95 percent of the average wholesale price for the drug.

''(E) CLASSES OF DRUGS.—For purposes of this paragraph, each of the following shall be treated as a separate class of drugs:

''(i) SOLE SOURCE DRUGS.—A sole source drug which for purposes of this paragraph means a drug or biological that is not a multiple source drug (as defined in subclauses (I) and (II) of section 1927(k)(7)(A)(i)) and is not a drug approved under an abbreviated new drug application under section 355(j) of the Federal Food, Drug, and Cosmetic Act.

''(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—Innovator multiple source drugs (as defined in section 1927(k)(7)(A)(ii)).

''(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—Noninnovator multiple source drugs (as defined in section 1927(k)(7)(A)(iii)).

''(F) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION FACTORS.—Additional expenditures resulting from this paragraph and paragraph (14)(C) in a year shall not be taken into account in establishing the conversion factor for that year.''.

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(14), as redesignated by paragraph (1)(A), is amended by adding at the end the following new subparagraph:

''(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory procedure classification groups (APCs) with respect to drugs to $50 per administration.''.

(3) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

''(E) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory procedure codes established separately for drugs.''.

(4) PAYMENT FOR PASS THROUGH DRUGS.—Clause (i) of section 1833(t)(6)(D) (42 U.S.C. 1395l(t)(6)(D)) is amended by inserting after ''under section 1842(o)'' the following: ''(or if the drug is covered under a competitive acquisition contract under section 1847A for an area, an amount determined by the Secretary equal to the average price for the drug for that area and year established under such section as calculated and applied by the Secretary for purposes of this paragraph)''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2004.

(b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

(1) IN GENERAL.—Section 1833(t)(14), as so redesignated and amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost.''.

(2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2) is amended—

(A) in subparagraph (F), by striking ''and'' at the end;

(B) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(H) with respect to devices of brachytherapy, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.''.

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(13)(B) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

(c) APPLICATION OF FUNCTIONAL EQUIVALENCE TEST.—

(1) IN GENERAL.—Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—The Secretary may not apply a 'functional equivalence' payment standard (including such standard promulgated on November 1, 2002) or any other similar standard in order to deem a particular drug or biological to be identical to or similar to another drug or biological with respect to its mechanism of action or clinical effect to deny pass-through status to new drugs or biologics or to remove such status of an existing eligible drug or biologic under this paragraph unless—

''(i) the Secretary develops by regulation (after providing notice and a period for public comment) criteria for the application of such standard; and

''(ii) such criteria provide for coordination with the Federal Food and Drug Administration and require scientific studies that show the clinical relationship between the drugs or biologicals treated as functionally equivalent.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of the enactment of this Act, unless such application was being made to such drug or biological prior to June 13, 2003.

(d) HOSPITAL ACQUISITION COST STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the costs incurred by hospitals in acquiring covered outpatient drugs for which payment is made under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(2) DRUGS COVERED.—The study in paragraph (1) shall not include those drugs for which the acquisition costs is less than $50 per administration.

(3) REPRESENTATIVE SAMPLE OF HOSPITALS.—In conducting the study under paragraph (1), the Secretary shall collect data from a statistically valid sample of hospitals with an urban/rural stratification.

(4) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations with respect to the following:

(A) Whether the study should be repeated, and if so, how frequently.

(B) Whether the study produced useful data on hospital acquisition cost.

(C) Whether data produced in the study is appropriate for use in making adjustments to payments for drugs and biologicals under section 1847A of the Social Security Act.

(D) Whether separate estimates can made of overhead costs, including handing and administering costs for drugs.

SEC. 622. PAYMENT FOR AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 410(a), is amended—

(1) in paragraph (2)(E), by inserting ''consistent with paragraph (11)'' after ''in an efficient and fair manner''; and

(2) by adding at the end the following new paragraph:

''(11) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year, the portion of the payment amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

''(A) For 2004, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

''(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

''(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

''(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

''(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.''.

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

''(12) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to such miles.''.

(c) GAO REPORT ON COSTS AND ACCESS.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under section 1834(l) of the Social Security Act, as amended by this section). Not later than December 31, 2007, the Comptroller General shall submit to Congress a final report on such access and supply.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulance services furnished on or after January 1, 2004.

SEC. 623. RENAL DIALYSIS SERVICES.

(a) DEMONSTRATION OF ALTERNATIVE DELIVERY MODELS.—

(1) USE OF ADVISORY BOARD.—In carrying out the demonstration project relating to improving care for people with end-stage renal disease through alternative delivery models (as published in the Federal Register of June 4, 2003), the Secretary shall establish an advisory board comprised of representatives described in paragraph (2) to provide advice and recommendations with respect to the establishment and operation of such demonstration project.

(2) REPRESENTATIVES.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The medicare payment advisory commission, established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(D) The National Kidney Foundation.

(E) The National Institute of Diabetes and Digestive and Kidney Diseases of National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(I) providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking ''and (C)'' and inserting '', (C), and (D)'';

(B) in subparagraph (B), by striking ''In the case'' and inserting ''Subject to subparagraph (D), in the case''; and

(C) by adding at the end the following new subparagraph:

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''.

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)), as amended by subsection (b), is further amended by striking ''Until'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and until''.

(c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent.

SEC. 624. ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 1-YEAR MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking ''and 2002'' and inserting ''2002, and 2004''.

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2003, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and

under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) IDENTIFICATION OF CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps under section 1833(g)(4) of the Social Security Act (42 U.S.C. 1395l(g)(4)).

(2) REPORTS TO CONGRESS.—

(A) PRELIMINARY REPORT.—Not later than July 1, 2004, the Secretary shall submit to Congress a preliminary report on the conditions and diseases identified under paragraph (1).

(B) FINAL REPORT.—Not later than September 1, 2004, the Secretary shall submit to Congress a final report on such conditions and diseases.

(C) RECOMMENDATIONS.—Not later than October 1, 2004, the Secretary shall submit to Congress a recommendation of criteria, with respect to such conditions and disease, under which a waiver of the therapy caps would apply.

(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL THERAPIST SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access to physical therapist services in States authorizing such services without a physician referral and in States that require such a physician referral. The study shall—

(A) examine the use of and referral patterns for physical therapist services for patients age 50 and older in States that authorize such services without a physician referral and in States that require such a physician referral;

(B) examine the use of and referral patterns for physical therapist services for patients who are medicare beneficiaries;

(C) examine the potential effect of prohibiting a physician from referring patients to physical therapy services owned by the physician and provided in the physician's office;

(D) examine the delivery of physical therapists' services within the facilities of Department of Defense; and

(E) analyze the potential impact on medicare beneficiaries and on expenditures under the medicare program of eliminating the need for a physician referral and physician certification for physical therapist services under the medicare program.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

SEC. 625. ADJUSTMENT TO PAYMENTS FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended in the last sentence by inserting ''and each of fiscal years 2004 through 2008'' after ''In each of the fiscal years 1998 through 2002''.

SEC. 626. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE FOR ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—Section 1833(o) (42 U.S.C. 1395l(o)) is amended—

(1) in paragraph (1), by striking ''no more than the limits established under paragraph (2)'' and inserting ''no more than the amount of payment applicable under paragraph (2)''; and

(2) in paragraph (2), to read as follows:

''(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

''(B) The Secretary or a carrier may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

''(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.''.

(b) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting ''(and includes shoes described in section 1861(s)(12))'' after ''in section 1861(s)(9)''.

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 2004.

SEC. 627. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: ''No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2004. The Secretary of Health and Human Services shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 628. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611(a) and 612(a) is amended—

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraph (W);

(B) by adding ''and'' at the end of subparagraph (X); and

(C) by adding at the end the following new subparagraph:

''(Y) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (yy));''; and

(2) by adding at the end the following new subsection:

''Intravenous Immune Globulin

''(yy) The term 'intravenous immune globulin' means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.''.

(b) PAYMENT AS A DRUG OR BIOLOGICAL.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting ''(including intravenous immune globulin (as defined in section 1861(yy)))'' after ''with respect to drugs and biologicals''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 629. MEDICARE COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by sections 611 and 612, is amended—

(1) in subparagraph (W), by striking ''and'' at the end;

(2) in subparagraph (X), by adding ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(Y) diabetes screening tests and services (as defined in subsection (yy));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611 and 612, is further amended by adding at the end the following new subsection:

''Diabetes Screening Tests and Services

''(yy)(1) The term 'diabetes screening tests' means diagnostic testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

''(A) a fasting plasma glucose test; and

''(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

''(2) For purposes of paragraph (1), the term 'individual at risk for diabetes' means an individual who has any, a combination of, or all of the following risk factors for diabetes:

''(A) A family history of diabetes.

''(B) Overweight defined as a body mass index greater than or equal to 25 kg/m2.

''(C) Habitual physical inactivity.

''(D) Belonging to a high-risk ethnic or racial group.

''(E) Previous identification of an elevated impaired fasting glucose.

''(F) Identification of impaired glucose tolerance.

''(G) Hypertension.

''(H) Dyslipidemia.

''(I) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

''(J) Polycystic ovary syndrome.

''(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.''.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by sections 611 and 612, is amended—

(1) by striking ''and'' at the end of subparagraph (J);

(2) by striking the semicolon at the end of subparagraph (K) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(L) in the case of a diabetes screening tests or service (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 701. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDER YEAR UPDATE.—

(1) IN GENERAL.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking ''each fiscal year (beginning with fiscal year 2002)'' and inserting ''fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)''; and

(ii) by inserting ''or year'' after ''the fiscal year'';

(B) in paragraph (3)(B)(ii)(II), by striking ''any subsequent fiscal year'' and inserting ''2004 and any subsequent year'';

(C) in paragraph (3)(B)(iii), by inserting ''or year'' after ''fiscal year'' each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting ''or year'' after ''fiscal year'' each place it appears; and

(ii) by inserting ''or years'' after ''fiscal years''; and

(E) in paragraph (5), by inserting ''or year'' after ''fiscal year''.

(2) TRANSITION RULE.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2003, shall be such amount (or amounts) for the previous calendar quarter.

(b) CHANGES IN UPDATES FOR 2004, 2005, AND 2006.—Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B), is amended—

(1) by striking ''or'' at the end of subclause (I);

(2) by redesignating subclause (II) as subclause (III);

(3) in subclause (III), as so redesignated, by striking ''2004'' and inserting ''2007''; and

(4) by inserting after subclause (I) the following new subclause:

''(II) each of 2004, 2005, and 2006 the home health market basket percentage increase minus 0.4 percentage points; or''.

SEC. 702. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

SEC. 703. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term ''activities of daily living'' means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle B—Chronic Care Improvement

SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

Title XVIII is amended by inserting after section 1806 the following new section:

''CHRONIC CARE IMPROVEMENT

''SEC. 1807. (a) IN GENERAL.—

''(1) IN GENERAL.—The Secretary shall establish a process for providing chronic care improvement programs in each CCIA region for medicare beneficiaries who are not enrolled under part C and who have certain chronic conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, prostate and colon cancer, hypertension, or other disease as identified by the Secretary as appropriate for chronic care improvement. Such a process shall begin to be implemented no later than 1 year after the date of the enactment of this section.

''(2) TERMINOLOGY.—For purposes of this section:

''(A) CCIA REGION.—The term 'CCIA region' means a chronic care improvement administrative region delineated under subsection (b)(2).

''(B) CHRONIC CARE IMPROVEMENT PROGRAM.—The terms 'chronic care improvement program' and 'program' means such a program provided by a contractor under this section.

''(C) CONTRACTOR.—The term 'contractor' means an entity with a contract to provide a chronic care improvement program in a CCIA region under this section.

''(D) INDIVIDUAL PLAN.—The term 'individual plan' means a chronic care improvement plan established under subsection (c)(5) for an individual.

''(3) CONSTRUCTION.—Nothing in this section shall be construed as expanding the amount, duration, or scope of benefits under this title.

''(b) COMPETITIVE BIDDING PROCESS.—

''(1) IN GENERAL.—Under this section the Secretary shall award contracts to qualified

entities for chronic care improvement programs for each CCIA region under this section through a competitive bidding process.

''(2) PROCESS.—Under such process—

''(A) the Secretary shall delineate the United States into multiple chronic care improvement administrative regions; and

''(B) the Secretary shall select at least 2 winning bidders in each CCIA region on the basis of the ability of each bidder to carry out a chronic care improvement program in accordance with this section, in order to achieve improved health and financial outcomes.

''(3) ELIGIBLE CONTRACTOR.—A contractor may be a disease improvement organization, health insurer, provider organization, a group of physicians, or any other legal entity that the Secretary determines appropriate.

''(c) CHRONIC CARE IMPROVEMENT PROGRAMS.—

''(1) IN GENERAL.—Each contract under this section shall provide for the operation of a chronic care improvement program by a contractor in a CCIA region consistent with this subsection.

''(2) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS.—Each contractor shall have a method for identifying medicare beneficiaries in the region to whom it will offer services under its program. The contractor shall identify such beneficiaries through claims or other data and other means permitted consistent with applicable disclosure provisions.

''(3) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each beneficiary identified under paragraph (2) as a prospective participant in one or more programs concerning participation in a program. Such communication may be made by the Secretary (or on behalf of the Secretary) and shall include information on the following:

''(A) A description of the advantages to the beneficiary in participating in a program.

''(B) Notification that the contractor offering a program may contact the beneficiary directly concerning such participation.

''(C) Notification that participation in a program is voluntary.

''(D) A description of the method for the beneficiary to select the single program in which the beneficiary wishes to participate and for declining to participate and a method for obtaining additional information concerning such participation.

''(4) PARTICIPATION.—A medicare beneficiary may participate in only one program under this section and may terminate participation at any time in a manner specified by the Secretary.

''(5) INDIVIDUAL CHRONIC CARE IMPROVEMENT PLANS.—

''(A) IN GENERAL.—For each beneficiary participating in a program of a contractor under this section, the contractor shall develop with the beneficiary an individualized, goal-oriented chronic care improvement plan.

''(B) ELEMENTS OF INDIVIDUAL PLAN.—Each individual plan developed under subparagraph (A) shall include a single point of contact to coordinate care and the following, as appropriate:

''(i) Self-improvement education for the beneficiary (such as education for disease management through medical nutrition therapy) and support education for health care providers, primary caregivers, and family members.

''(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

''(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

''(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

''(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

''(C) CONTRACTOR RESPONSIBILITIES.—In establishing and carrying out individual plans under a program, a contractor shall, directly or through subcontractors—

''(i) guide participants in managing their health, including all their co-morbidities, and in performing activities as specified under the elements of the plan;

''(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

''(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

''(6) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for programs and contractors under this section.

''(7) ACCREDITATION.—The Secretary may provide that programs that are accredited by qualified organizations may be deemed to meet such requirements under this section as the Secretary may specify.

''(c) CONTRACT TERMS.—

''(1) IN GENERAL.—A contract under this section shall contain such terms and conditions as the Secretary may specify consistent with this section. The Secretary may not enter into a contract with an entity under this section unless the entity meets such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the population to be served.

''(2) USE OF SUBCONTRACTORS PERMITTED.—A contractor may carry out a program directly or through contracts with subcontractors.

''(3) BUDGET NEUTRAL PAYMENT CONDITION.—In entering into a contract with an entity under this subsection, the Secretary shall establish payment rates that assure that there will be no net aggregate increase in payments under this title over any period of 3 years or longer, as agreed to by the Secretary. Under this section, the Secretary shall assure that medicare program outlays plus administrative expenses (that would not have been paid under this title without implementation of this section), including contractor fees, shall not exceed the expenditures that would have been incurred under this title for a comparable population in the absence of the program under this section for the 3-year contract period.

''(4) AT RISK RELATIONSHIP.—For purposes of section 1128B(b)(3)(F), a contract under this section shall be treated as a risk-sharing arrangement referred to in such section.

''(5) PERFORMANCE STANDARDS.—Payment to contractors under this section shall be subject to the contractor's meeting of clinical and financial performance standards set by the Secretary.

''(6) CONTRACTOR OUTCOMES REPORT.—Each contractor offering a program shall monitor and report to the Secretary, in a manner specified by the Secretary, the quality of care and efficacy of such program in terms of—

''(A) process measures, such as reductions in errors of treatment and rehospitalization rates;

''(B) beneficiary and provider satisfaction;

''(C) health outcomes; and

''(D) financial outcomes.

''(7) PHASED IN IMPLEMENTATION.—Nothing in this section shall be construed as preventing the Secretary from phasing in the implementation of programs.

''(d) BIANNUAL OUTCOMES REPORTS.—The Secretary shall submit to the Congress biannual reports on the implementation of this section. Each such report shall include information on—

''(1) the scope of implementation (in terms of both regions and chronic conditions);

''(2) program design; and

''(3) improvements in health outcomes and financial efficiencies that result from such implementation.

''(e) CLINICAL TRIALS.—The Secretary shall conduct randomized clinical trials, that compare program participants with medicare beneficiaries who are offered, but decline, to participate, in order to assess the potential of programs to—

''(1) reduce costs under this title; and

''(2) improve health outcomes under this title.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary, in appropriate part from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for contracts with chronic care improvement programs under this section.

''(g) LIMITATION ON FUNDING.—In no case shall the funding under this section exceed $100,000,000 over a period of 3 years.''.

SEC. 722. CHRONIC CARE IMPROVEMENT UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(1) by amending subsection (e) to read as follows:

''(e) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS FOR BENEFICIARIES WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—

''(1) IN GENERAL.—Each Medicare+Choice organization with respect to each Medicare+Choice plan it offers shall have in effect, for enrollees with multiple or sufficiently severe chronic conditions, a chronic care improvement program that is designed to manage the needs of such enrollees and that meets the requirements of this subsection.

''(2) ENROLLEE WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—For purposes of this subsection, the term 'enrollee with multiple or sufficiently severe chronic conditions' means, with respect to an enrollee in a Medicare+Choice plan of a Medicare+Choice organization, an enrollee in the plan who has one or more chronic conditions, such as congestive heart failure, diabetes, COPD, stroke, prostate and colon cancer, hypertension, or other disease as identified by the organization as appropriate for chronic care improvement.

''(3) GENERAL REQUIREMENTS.—

''(A) IN GENERAL.—Each chronic care improvement program under this subsection shall be conducted consistent with this subsection.

''(B) IDENTIFICATION OF ENROLLEES.—Each such program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet the organization's criteria for participation under the program.

''(C) DEVELOPMENT OF PLANS.—For an enrollee identified under subparagraph (B) for participation in a program, the program shall develop, with the enrollee's consent, an individualized, goal-oriented chronic care improvement plan for chronic care improvement.

''(D) ELEMENTS OF PLANS.—Each chronic care improvement plan developed under subparagraph (C) shall include a single point of contact to coordinate care and the following, as appropriate:

''(i) Self-improvement education for the enrollee (such as education for disease management through medical nutrition therapy)

and support education for health care providers, primary caregivers, and family members.

''(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

''(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

''(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

''(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

''(E) ORGANIZATION RESPONSIBILITIES.—In establishing and carrying out chronic care improvement plans for participants under this paragraph, a Medicare+Choice organization shall, directly or through subcontractors—

''(i) guide participants in managing their health, including all their co-morbidities, and in performing the activities as specified under the elements of the plan;

''(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

''(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

''(3) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for chronic care improvement programs under this section.

''(4) ACCREDITATION.—The Secretary may provide that chronic care improvement programs that are accredited by qualified organizations may be deemed to meet such requirements under this subsection as the Secretary may specify.

''(5) OUTCOMES REPORT.—Each Medicare+Choice organization with respect to its chronic care improvement program under this subsection shall monitor and report to the Secretary information on the quality of care and efficacy of such program as the Secretary may require.''; and

(2) by amending subparagraph (I) of subsection (c)(1) to read as follows:

''(I) CHRONIC CARE IMPROVEMENT PROGRAM.—A description of the organization's chronic care improvement program under subsection (e).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning on or after 1 year after the date of the enactment of this Act.

SEC. 723. INSTITUTE OF MEDICINE REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a study of the barriers to effective integrated care improvement for medicare beneficiaries with multiple or severe chronic conditions across settings and over time and to submit a report under subsection (b).

(2) SPECIFIC ITEMS.—The study shall examine the statutory and regulatory barriers to coordinating care across settings for medicare beneficiaries in transition from one setting to another (such as between hospital, nursing facility, home health, hospice, and home). The study shall specifically identify the following:

(A) Clinical, financial, or administrative requirements in the medicare program that present barriers to effective, seamless transitions across care settings.

(B) Policies that impede the establishment of administrative and clinical information systems to track health status, utilization, cost, and quality data across settings.

(C) State-level requirements that may present barriers to better care for medicare beneficiaries.

(3) CONSULTATION.—The study under this subsection shall be conducted in consultation with experts in the field of chronic care, consumers, and family caregivers, working to integrate care delivery and create more seamless transitions across settings and over time.

(b) REPORT.—The report under this subsection shall be submitted to the Secretary and Congress not later than 18 months after the date of the enactment of this Act.

SEC. 724. MEDPAC REPORT.

(a) EVALUATION.—shall conduct an evaluation that includes a description of the status of the implementation of chronic care improvement programs under section 1807 of the Social Security Act, the quality of health care services provided to individuals in such program, the health status of the participants of such program, and the cost savings attributed to implementation of such program.

(b) REPORT.—Not later than 2 years after the date of implementation of such chronic care improvement programs, the Commission shall submit a report on such evaluation.

Subtitle C—Other Provisions

SEC. 731. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.''.

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting ''the efficient provision of'' after ''expenditures for''.

(c) APPLICATION OF DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following: ''Members of the Commission shall be treated as employees of the Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

(d) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services. The Commission shall examine data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the ''demonstration project'') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 u.s.c. 1395fff). In no case may a home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in not more than 5 States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day care services.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later 30 months after the commencement of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the

project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) MEDICAL ADULT DAY CARE FACILITY.—The term ''medical adult day care facility'' means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) MEDICAL ADULT DAY CARE SERVICES.—The term ''medical adult day care services'' means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 733. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting ''consistent with subsection (k)'' after ''the Secretary shall ensure''; and

(B) by adding at the end the following new subsection:

''(k) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

''(1) CRITERIA AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the criteria the Secretary uses in making national coverage determinations, including how evidence to demonstrate that a procedure or device is reasonable and necessary is considered.

''(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

''(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

''(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 12 months after the date of the request.

''(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period that begins on the date a request for a national coverage determination is made, the Secretary shall—

''(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

''(B) provide a 30-day period for public comment on such draft;

''(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

''(D) include in such final decision summaries of the public comments received and responses thereto;

''(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and.

''(F) in the case of a decision to grant the coverage determination, assign or temporary or permanent code during the 60-day period referred to in subparagraph (C).

''(4) CONSULTATION WITH OUTSIDE EXPERTS IN CERTAIN NATIONAL COVERAGE DETERMINATIONS.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

''(5) LOCAL COVERAGE DETERMINATION PROCESS.—With respect to local coverage determinations made on or after January 1, 2004—

''(A) PLAN TO PROMOTE CONSISTENCY OF COVERAGE DETERMINATIONS.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

''(B) CONSULTATION.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

''(C) DISSEMINATION OF INFORMATION.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

''(6) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the terms 'national coverage determination' and 'local coverage determination' have the meaning given such terms in paragraphs (1)(B) and (2)(B), respectively, of section 1869(f).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to national and local coverage determinations as of January 1, 2004.

(b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.—

(1) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement paragraph (1)).

(3) EFFECTIVE DATE.—This subsection shall apply to clinical trials begun before, on, or after the date of the enactment of this Act and to items and services furnished on or after such date.

(c) ISSUANCE OF TEMPORARY NATIONAL CODES.—Not later than January 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act.

SEC. 734. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1848(i) (42 U.S.C. 1395w–4(i)) is amended by adding at the end the following new paragraph:

''(4) TREATMENT OF CERTAIN INPATIENT PHYSICIAN PATHOLOGY SERVICES.—

''(A) IN GENERAL.—With respect to services furnished on or after January 1, 2001, and before January 1, 2006, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary shall treat such component as a service for which payment shall be made to the laboratory under this section and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) or as a hospital outpatient service for which payment is made to the hospital under section 1833(t).

''(B) DEFINITIONS.—In this paragraph:

''(i) COVERED HOSPITAL.—

''(I) IN GENERAL.—The term 'covered hospital' means, with respect to an inpatient or outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a carrier with a contract under section 1842 and not to the hospital.

''(II) CHANGE IN OWNERSHIP DOES NOT AFFECT DETERMINATION.—A change in ownership with respect to a hospital on or after the date referred to in subclause (I) shall not affect the determination of whether such hospital is a covered hospital for purposes of such subclause.

''(ii) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who is entitled to benefits under part A, or enrolled under this part, or both, but is not enrolled in any of the following:

''(I) A Medicare+Choice plan under part C.

''(II) A plan offered by an eligible organization under section 1876.

''(III) A program of all-inclusive care for the elderly (PACE) under section 1894.

''(IV) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).''.

(b) CONFORMING AMENDMENT.—Section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–550), as enacted into law by section 1(a)(6) of Public Law 106–554, is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section shall take effect as if included in the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

SEC. 735. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

(e) WAIVER AUTHORITY.—The Secretary may waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

TITLE VIII—MEDICAID

SEC. 801. CONTINUATION OF MEDICAID DSH ALLOTMENT ADJUSTMENTS UNDER BIPA 2000.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f))—

(1) in paragraph (2)—

(A) in the heading, by striking ''THROUGH 2002'' and inserting ''THROUGH 2000'';

(B) by striking ''ending with fiscal year 2002'' and inserting ''ending with fiscal year 2000''; and

(C) in the table in such paragraph, by striking the columns labeled ''FY 01'' and ''FY02'';

(2) in paragraph (3)(A), by striking ''paragraph (2)'' and inserting ''paragraph (4)''; and

(3) in paragraph (4), as added by section 701(a)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554)—

(A) by striking ''FOR FISCAL YEARS 2001 AND 2002'' in the heading;

(B) in subparagraph (A), by striking ''Notwithstanding paragraph (2), the'' and inserting ''The'';

(C) in subparagraph (C)—

(i) by striking ''NO APPLICATION'' and inserting ''APPLICATION''; and

(ii) by striking ''without regard to'' and inserting ''taking into account''.

(b) INCREASE IN MEDICAID DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Effective for DSH allotments beginning with fiscal year 2003, the item in the table contained in section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r–4(f)(2)) for the District of Columbia for the DSH allotment for FY 00 (fiscal year 2000) is amended by striking ''32'' and inserting ''49''.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the application of section 1923(f)(4) of the Social Security Act (as amended by subsection (a)) to the District of Columbia for fiscal year 2003 and subsequent fiscal years.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to DSH allotments for fiscal years beginning with fiscal year 2003.

SEC. 802. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE TO 3 PERCENT IN FISCAL YEAR 2003.

(a) INCREASE IN DSH FLOOR.—Section 1923(f)(5) of the Social Security Act (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking ''fiscal year 1999'' and inserting ''fiscal year 2001'';

(2) by striking ''August 31, 2000'' and inserting ''August 31, 2002'';

(3) by striking ''1 percent'' each place it appears and inserting ''3 percent''; and

(4) by striking ''fiscal year 2001'' and inserting ''fiscal year 2003''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect as if enacted on October 1, 2002, and apply to DSH allotments under title XIX of the Social Security Act for fiscal year 2003 and each fiscal year thereafter.

SEC. 803. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: ''(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)''.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

SEC. 901. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) CONSTRUCTION.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

''Supplier

''(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.''.

SEC. 902. ISSUANCE OF REGULATIONS.

(a) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

''(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

''(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

''(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 903. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(a), is amended by adding at the end the following new subsection:

''(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

''(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

''(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

''(2)(A) If—

''(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

''(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

''(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

''(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 904. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than one year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(a), is amended by adding at the end the following new subsection:

''(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

Subtitle B—Contracting Reform

SEC. 911. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors

under this section, taking into account performance quality as well as price and other factors.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

''(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

''(B) CONSULTATION.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

''(A) IN GENERAL.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the 'False Claims Act').

''(4) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,'' in the matter preceding clause (i); and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'' in clause (i);

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,''; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2010.

(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of the enactment of this Act and before the date specified under subparagraph (A), the Secretary may enter into new agreements under section 1816 of the Social Security Act (42 U.S.C. 1395h) without regard to any of the provider nomination provisions of such section.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1), is amended by adding at the end the following new subsection:

''(e) REQUIREMENTS FOR INFORMATION SECURITY.—

''(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

''(2) INDEPENDENT AUDITS.—

''(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

''(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

''(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

''(B) DEADLINE FOR INITIAL EVALUATION.—

''(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

''(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

''(C) REPORTS ON EVALUATIONS.—

''(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

''(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

''(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.''.

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 921. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a), is amended by adding at the end the following new subsection:

''(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.''.

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2004, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a) and subsection (b), is further amended by adding at the end the following new subsection:

''(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2004.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

''(b) ENHANCED EDUCATION AND TRAINING.—

''(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal

Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2005 and 2006 and such sums as may be necessary for succeeding fiscal years.

''(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

''(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) a provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a supplier with fewer than 10 full-time-equivalent employees.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

''(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

''(1) provides answers in an easily accessible format to frequently asked questions, and

''(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

''(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

''(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term ''small providers of services or suppliers'' means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2005, $1,000,000, and

(2) for fiscal year 2006, $6,000,000.

SEC. 923. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

''(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

''(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.''.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII, as previously amended, is amended by inserting after section 1809 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1810. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

''(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

''(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary;

''(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

''(C) assistance to such individuals in presenting information under section 1860D–2(b)(4)(D)(v); and

''(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

''(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.''.

(c) DEADLINE FOR APPOINTMENT.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(d) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(e) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''The Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free number 1–800–MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 924. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 925. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking ''hospice services'' and inserting ''hospice care and post-hospital extended care services''; and

(B) by inserting before the period at the end the following: ''and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described

in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another other officer of the Department.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA (114 Stat. 2763A–543), is amended by striking ''of the Social Security Administration''.

SEC. 932. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision'';

(2) in paragraph (1)(F)—

(A) by striking clause (ii);

(B) by striking ''PROCEEDING'' and all that follows through ''DETERMINATION'' and inserting ''DETERMINATIONS AND RECONSIDERATIONS''; and

(C) by redesignating subclauses (I) and (II) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

(3) by adding at the end the following new paragraph:

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review panel—

''(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

''(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

''(D) REVIEW PANELS.—For purposes of this subsection, a 'review panel' is a panel consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection (c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

(2) by adding at the end the following new subparagraph:

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

(d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases of termination.

(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year 2005 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

SEC. 933. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 932(a), is further amended by adding at the end the following new paragraph:

''(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by BIPA, is amended by adding at the end the following new paragraphs:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the determination shall include—

''(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

''(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

''(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section; and

''(B) the person provided such notice may obtain, upon request, the specific provision of the policy, manual, or regulation used in making the determination.

''(5) REQUIREMENTS OF NOTICE OF REDETERMINATIONS.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the redetermination shall include—

''(i) the specific reasons for the redetermination;

''(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

''(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

''(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

''(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

''(C) the person provided such notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting ''be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)'' after ''in writing, ''; and

(B) by inserting ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision,''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)), as amended by BIPA, is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

(B) by adding at the end the following new paragraph:

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking ''prepare'' and inserting ''submit'' and by striking ''with respect to'' and all that follows through ''and relevant policies''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking ''sufficient training and expertise in medical science and legal matters'' and inserting ''sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing''; and

(B) by adding at the end the following new subparagraph:

''(K) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party.

''(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

(B) by adding at the end the following new subsection:

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) the individual is not involved in the provision of items or services in the case under review;

''(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

''(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

''(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

''(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''not fewer than 12 qualified independent contractors under this subsection'' and inserting ''with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection''.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

(5) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 934. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by sections 912(b), 921(b)(1), and 921(c)(1), is further amended by adding at the end the following new subsection:

''(h) CONDUCT OF PREPAYMENT REVIEW.—

''(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

''(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

''(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

''(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

''(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

''(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

''(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 935. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(f) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) HARDSHIP.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

''(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

''(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

''(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

''(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

''(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

''(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

''(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

''(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a

limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services or supplier—

''(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

''(II) the nature of the problems identified in such evaluation; and

''(III) the steps that the provider of services or supplier should take to address the problems; and

''(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

''(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(7) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

''(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

''(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

''(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: ''; ENROLLMENT PROCESSES''; and

(2) by adding at the end the following new subsection:

''(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) ENROLLMENT PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

''(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

''(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

''(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 937. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) CLAIMS.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) PERMITTING USE OF CORRECTED AND SUPPLEMENTARY DATA.—

(1) IN GENERAL.—Section 1886(d)(10)(D)(vi) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

''Notwithstanding subclause (I), a hospital may submit, and the Secretary may accept upon verification, data that corrects or supplements the data described in such subclause without regard to whether the corrected or supplementary data relate to a cost report that has been settled.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to fiscal years beginning with fiscal year 2004.

(3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS PERMITTED FOR FISCAL YEAR 2004.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a hospital may submit (or resubmit) an application for a change described in section 1886(d)(10)(C)(i)(II) of the Social Security Act for fiscal year 2004 if the hospital demonstrates on a timely basis to the satisfaction of the Secretary that the use of corrected or supplementary data under

the amendment made by paragraph (1) would materially affect the approval of such an application.

(B) APPLICATION OF BUDGET NEUTRALITY.—If one or more hospital's applications are approved as a result of paragraph (1) and subparagraph (A) for fiscal year 2004, the Secretary shall make a proportional adjustment in the standardized amounts determined under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) for fiscal year 2004 to assure that approval of such applications does not result in aggregate payments under section 1886(d) of such Act that are greater or less than those that would otherwise be made if paragraph (1) and subparagraph (A) did not apply.

SEC. 938. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 933(d)(2)(B), is further amended by adding at the end the following new subsection:

''(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

''(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

''(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

''(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

''(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

''(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

''(3) REQUEST FOR PRIOR DETERMINATION.—

''(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

''(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

''(4) RESPONSE TO REQUEST.—

''(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

''(i) the item or service is so covered;

''(ii) the item or service is not so covered; or

''(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

''(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

''(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

''(5) EFFECT OF DETERMINATIONS.—

''(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

''(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

''(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

''(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

''(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

''(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

''(6) LIMITATION ON FURTHER REVIEW.—

''(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

''(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

''(i) decides not to seek a prior determination under this subsection with respect to items or services; or

''(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

''(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.''.

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ''advance beneficiary notice'' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

Subtitle V—Miscellaneous Provisions

SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for, or clinical examples of, evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term ''teaching settings'' are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 942. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 921(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

(b) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

''(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

''(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

''(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

''(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

''(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

''(i) set forth the criteria for making determinations under subparagraph (A); and

''(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

''(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

''(E) For purposes of this paragraph:

''(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

''(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).''.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) PROCESS FOR ADOPTION OF ICD CODES AS DATA STANDARD.—Section 1172(f) (42 U.S.C. 1320d–1(f)) is amended by inserting after the first sentence the following: ''Notwithstanding the preceding sentence, if the National Committee on Vital and Health Statistics has not made a recommendation to the Secretary before the date of the enactment of this sentence, with respect to the adoption of the International Classification of Diseases, 10th Revision, Procedure Coding System ('ICD–10–PCS') and the International Classification of Diseases, 10th Revision, Clinical Modification ('ICD–10–CM') as a standard under this part for the reporting of diagnoses, the Secretary may implement ICD-10-PCS only with respect to inpatient services as such a standard.''.

SEC. 943. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 944. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(B) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 945. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the ''Advisory Group'') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 946. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 947. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking ''and'' at the end;

(B) in subparagraph (S), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

(2) by adding at the end of subsection (b) the following new paragraph:

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 948. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy'' and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking ''subclause (I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 949. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

SEC. 950. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

''(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 951. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days described in subclause (II) of section 1886(d)(5)(F)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) used in computing the disproportionate patient percentage under such section for that hospital. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 952. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A) (42 U.S.C. 1395u(b)(6)(A)) is amended by striking ''or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service,'' and inserting ''or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such other program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility'' and inserting ''except to an employer, entity, or other person''.

(c) EFFECTIVE DATE.—The amendments made by section shall apply to payments made on or after the date of the enactment of this Act.

SEC. 953. OTHER PROVISIONS.

(a) GAO REPORTS ON THE PHYSICIAN COMPENSATION.—

(1) SUSTAINABLE GROWTH RATE AND UPDATES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) PHYSICIAN COMPENSATION GENERALLY.—Not later than 12 months after the date of

the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c) GAO REPORT ON FLEXIBILITY IN APPLYING HOME HEALTH CONDITIONS OF PARTICIPATION TO PATIENTS WHO ARE NOT MEDICARE BENEFICIARIES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to such recipients.

(d) OIG REPORT ON NOTICES RELATING TO USE OF HOSPITAL LIFETIME RESERVE DAYS.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 1001. IMPORTATION OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

"SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

''(a) DEFINITIONS.—In this section:

''(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

''(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

''(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

''(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

''(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

''(C) an infused drug (including a peritoneal dialysis solution);

''(D) an intravenously injected drug; or

''(E) a drug that is inhaled during surgery.

''(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

''(5) WHOLESALER.—

''(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

''(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

''(b) REGULATIONS.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

''(c) LIMITATION.—The regulations under subsection (b) shall—

''(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

''(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

''(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

''(d) INFORMATION AND RECORDS.—

''(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

''(A) The name and quantity of the active ingredient of the prescription drug.

''(B) A description of the dosage form of the prescription drug.

''(C) The date on which the prescription drug is shipped.

''(D) The quantity of the prescription drug that is shipped.

''(E) The point of origin and destination of the prescription drug.

''(F) The price paid by the importer for the prescription drug.

''(G) Documentation from the foreign seller specifying—

''(i) the original source of the prescription drug; and

''(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

''(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

''(I) The name, address, telephone number, and professional license number (if any) of the importer.

''(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

''(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

''(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

''(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

''(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

''(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

''(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

''(i) is approved for marketing in the United States; and

''(ii) meets all labeling requirements under this Act.

''(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

''(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

''(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

''(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

''(e) TESTING.—The regulations under subsection (b) shall require—

''(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

''(2) if the tests are conducted by the importer—

''(A) that information needed to—

''(i) authenticate the prescription drug being tested; and

''(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

''(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

''(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

''(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

''(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

''(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

''(i) PROHIBITION OF DISCRIMINATION.—

''(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

''(2) DISCRIMINATION.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

''(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

''(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

''(j) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

''(k) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—

''(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

''(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

''(B) exercise discretion to permit individuals to make such importations in circumstances in which—

''(i) the importation is clearly for personal use; and

''(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

''(2) WAIVER AUTHORITY.—

''(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

''(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

''(3) DRUGS IMPORTED FROM CANADA.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

''(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

''(B) is accompanied by a copy of a valid prescription;

''(C) is imported from Canada, from a seller registered with the Secretary;

''(D) is a prescription drug approved by the Secretary under chapter V;

''(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

''(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

''(l) STUDIES; REPORTS.—

''(1) BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES.—

''(A) STUDY.—

''(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

''(I) importations of prescription drugs made under the regulations under subsection (b); and

''(II) information and documentation submitted under subsection (d).

''(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—

''(I) evaluate the compliance of importers with the regulations under subsection (b);

''(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

''(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

''(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(2) BY THE COMPTROLLER GENERAL.—

''(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

''(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

''(n) EFFECTIVENESS OF SECTION.—

''(1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

''(2) PROCEDURE.—The Secretary shall not submit a certification under paragraph (1) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

''(A)(i) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

''(ii) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

''(iii) identifies specifically the causes of the increased risk; and

''(iv)(I) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

''(II) if the Secretary determines that any measures described in subclause (I) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

''(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

''(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

''(ii) determines that the benefits do not outweigh the detriment.

''(o) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

''(p) CONDITIONS.—This section shall become effective only if the Secretary certifies to the Congress that implementation of this section will—

''(1) pose no additional risk to the public's health and safety; and

''(2) result in a significant reduction in the cost of covered products to the American consumer.''.

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking ''covered product in violation of section 804'' and inserting ''prescription drug in violation of section 804''; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking ''covered product pursuant to section 804(a)'' and inserting ''prescription drug under section 804(b)''.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 1101. SHORT TITLE.

This title may be cited as the ''Greater Access to Affordable Pharmaceuticals Act''.

SEC. 1102. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

''(B) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

''(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

''(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

''(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of

whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

''(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(II) the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

''(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.''; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking ''under the following'' and inserting ''by applying the following to each certification made under paragraph (2)(A)(vii)''; and

(ii) in clause (iii)—

(I) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted.''; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

''(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(aa) the date on which the court enters judgment reflecting the decision; or

''(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(bb) by striking subclause (II) and inserting the following:

''(II) if before the expiration of such period the district court decides that the patent has been infringed—

''(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

''(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(cc) in subclause (III), by striking ''on the date of such court decision.'' and inserting ''as provided in subclause (I); or''; and

(dd) by inserting after subclause (III) the following:

''(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II).'';

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

''(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under paragraph (2)(B) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).''.

(b) APPLICATIONS GENERALLY.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b), by striking paragraph (3) and inserting the following:

''(3) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

''(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

''(B) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

''(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

''(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

''(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.''; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking ''under the following'' and inserting ''by applying the following to each certification made under subsection (b)(2)(A)(iv)'';

(B) in subparagraph (C)—

(i) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.'';

(ii) in the second sentence—

(I) by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(II) by striking clause (i) and inserting the following:

''(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(I) the date on which the court enters judgment reflecting the decision; or

''(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(III) by striking clause (ii) and inserting the following:

''(ii) if before the expiration of such period the district court decides that the patent has been infringed—

''(I) if the judgment of the district court is appealed, the approval shall be made effective on—

''(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(II) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(IV) in clause (iii), by striking ''on the date of such court decision.'' and inserting ''as provided in clause (i); or''; and

(V) by inserting after clause (iii), the following:

''(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii).''; and

(iii) in the third sentence, by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

''(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).''.

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

''(5) The filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought by the applicant under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.''.

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 1103. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 1102) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

''(iv) 180-DAY EXCLUSIVITY PERIOD.—

''(I) DEFINITIONS.—In this paragraph:

''(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

''(bb) FIRST APPLICANT.—The term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

''(cc) SUBSTANTIALLY COMPLETE APPLICATION.—The term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

''(dd) TENTATIVE APPROVAL.—

''(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

''(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

''(II) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant.''; and

(2) by inserting after subparagraph (C) the following:

''(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

''(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

''(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

''(aa) the earlier of the date that is—

''(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

''(BB) 30 months after the date of submission of the application of the first applicant; or

''(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

''(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

''(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

''(CC) The patent expires.

''(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

''(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

''(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect

to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

''(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

''(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

''(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

''(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

''(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

''(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

''(II) no applicant shall be eligible for a 180-day exclusivity period.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term ''decision of a court'' as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 1104. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

''(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

''(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action.''; and

(2) by adding at the end the following:

''(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.''.

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 1105. REMEDIES FOR INFRINGEMENT.

Section 287 of title 35, United States Code, is amended by adding at the end the following:

''(d) CONSIDERATION.—In making a determination with respect to remedy brought for infringement of a patent that claims a drug or a method or using a drug, the court shall consider whether information on the patent was filed as required under 21 U.S.C. 355 (b) or (c), and, if such information was required to be filed but was not, the court may refuse to award treble damages under section 284.''.

SEC. 1106. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking ''(j)(5)(D)(ii)'' each place it appears and inserting ''(j)(5)(F)(ii)'';

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking ''(j)(5)(D)'' each place it appears and inserting ''(j)(5)(F)''; and

(3) in subsections (e) and (l), by striking ''505(j)(5)(D)'' each place it appears and inserting ''505(j)(5)(F)''.

The SPEAKER pro tempore. Pursuant to House Resolution 299, the gentleman from New York (Mr. RANGEL) and the gentleman from Louisiana (Mr. TAUZIN) each will control 30 minutes.

Mr. TAUZIN. Mr. Speaker, I yield 15 minutes to the gentleman from California (Mr. THOMAS) or his designee, and ask unanimous consent that he may control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

Mr. RANGEL. Mr. Speaker, I yield 15 minutes to the gentleman from Michigan (Mr. DINGELL) and ask unanimous consent that he be permitted to further allocate that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) is recognized for 15 minutes.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I appreciate the statement made by the gentleman from Louisiana (Mr. TAUZIN) that we all are concerned about our older citizens and those that are to follow, and certainly we all have to appreciate the fact that we are all here because we stand on someone else's shoulders, someone else who made the sacrifice, and I am very proud to share the responsibility of this bill with the gentleman from Michigan (Mr. DINGELL), who has dedicated his entire life, and his dad before him, in making certain that he and those of us who support him and what he believes in improves the quality of life of not only the seniors today.

It took us a long time to get where we are where people feel some degree of comfort that the Federal Government will be there for them, whether it is Social Security, whether it is Medicaid, whether it is Medicare. It has been government, yes, this government, this wonderful government, this government who gave me the GI bill, this government which allowed older citizens to have some degree of pride in having Social Security to cushion themselves from poverty, and this government that provided health care for the very poor, and under Medicare we had hoped that we would have provided prescription drugs for them.

I do not know when this animosity came against government, why we felt we had to starve these programs which some of us have been so proud of. Somebody asked how do you pay for your bill? This is a strange thing to ask, especially when the chairman of the Committee on the Budget is on the floor. He has been able to do magic with numbers over there. He started out with a $5.6 trillion surplus, and with magic converted it to a $3.4 trillion deficit. He can take $9 trillion and find some way to spend it in tax cuts. Even tonight, some $173 billion, $100 billion just found last night, and we will get $400 billion from what they have allocated, but we think that it takes twice that much.

Is that asking to do, is that something that we have to go to the Committee on the Budget for and ask? Can you sprinkle your magic powder on us and make it possible for the older people not to have gaps in services? Is it asking too much to treat them, not that they are wealthy in dollars and cents, but they are wealthy in terms of the investment they made in this country to make it possible for the multinationals and the wealthy people to get the tax breaks that they are getting, and it seems to me since compassion is not there, that maybe we can look at it as a cost savings vehicle.

How many senior citizens will not have to go to the hospitals which are so expensive, how much of a part of our health expenses is a part of the institutions which our seniors are forced to go

into? If you have to make a decision and you are in doubt, why not make the doubt in favor of the senior citizens? Everything that is missing in the Republican bill that is good, we put in our bill to make certain that it is better.

One thing that we are saying is this, do not hate the government until you do not have any need for it. And seniors when they read the difference of the bills, and you bet your life they can read, they may be old but they are not stupid. They can pick up the daily newspapers, and if they do not go to the pharmaceutical corporations but rather go to the local drugstore, they will find out in short order who is their best friend.

Do not knock the government. It is not as bad as some Members think. Give the people an opportunity so that we can say citizens, we appreciate all that you have done for us, and we in the Congress believe that the least we can do for you as you grow older is to ease your pain and, more important, the fear you have that once you go to the doctor that at least you will be able to get the drugs that are prescribed for your illness.

Mr. Speaker, we do not have to challenge each other's integrity, but I tell Members this, that there are Members on the other side of the aisle that hold Social Security in utter contempt. There are Members who talk about Medicare as though the communists created the package, and they resented it when it started, and they think it is worse than ever today.

What I am saying is let us do what they tell doctors to do, and do no harm. Let us leave here saying that at least on this day there was a substitute, they did not have to do it the way the majority would want.

Mr. Speaker, I yield the balance of my time to the gentleman from California (Mr. STARK), the ranking member of the Subcommittee on Health, and I ask unanimous consent that he may further allocate that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

(Mr. WILSON of South Carolina asked and was given permission to speak out of order and to revise and extend his remarks.)

SOUTH CAROLINA LOSES A LEGEND

Mr. WILSON of South Carolina. Mr. Speaker, it is with great sadness tonight that I announce that Senator Strom Thurmond passed away at 9:45. I was a former staff member of Senator Thurmond, my wife was a staff person for Senator Thurmond, and our three sons have been pages with his office.

With the death of Strom Thurmond, South Carolina has lost its greatest statesman of the 20th century, just as John Calhoun was the most revered South Carolinian of the 19th century. Strom Thurmond will never be replaced in the countless hearts of those who loved and respected him.

The entire Wilson family mourns this profound loss and we extend our sympathy to the Thurmond family.

Senator Strom Thurmond will endure as the leading example of a public servant due to his love and devotion to all the people of South Carolina regardless of status, race, politics or region.

He was our living legend. Strom's life was dedicated to achieving peace through strength, as shown by his military service in liberating Europe from Nazi fascists, his tireless work in fighting for a strong national defense in Congress which ultimately led to the defeat of Soviet communism.

□ 2300

He pioneered the development of the South Carolina Republican Party from effective nonexistence in the 1960s to majority status by the end of the century. He has been a role model of service to South Carolina's young people and our family has had three generations on his staff: my wife's two uncles were staff attorneys, my wife and I were interns, and our three oldest sons were pages. A distinguished highlight for our family was to host Senator Thurmond on the last Sunday before his last election in 1996 at the First Presbyterian Church in Columbia.

The legacy of Strom Thurmond will always be felt in South Carolina because of his steadfast integrity and the meaningful results of his thoughtful constituent service. He was my personal hero, and I will miss him dearly.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

Let me join in expressing the sorrow of the folks in Louisiana for your loss in South Carolina. We will pray for his soul.

Mr. Speaker, the Democratic substitute in this debate can be summed up rather easily. According to CBO, it will spend over a trillion dollars. It busts the budget. Therefore, it is on the floor with a budget waiver. It at the same time excludes and does not contain any of the reforms that the base bill includes, that are designed to save Medicare from failure, from insolvency. I am not predicting Medicare's failure or insolvency. CBO is. CRS is. Everyone who has estimated the strength of our Medicare system predicts very soon, in our lifetimes, it will go insolvent. None of the reforms that are designed to save Medicare from insolvency are here. In fact, the Democratic substitute piles on a trillion dollars' worth of expenses to the Medicare system with no reforms to make sure the system is saved.

When I mentioned earlier that you ought to test the credibility of arguments on this floor by what is said and what is fact and what is of record, let me take you back to the statements of the distinguished gentlewoman from California who criticized the base bill because CBO said it might mean that as much as 30 percent or so of employers might drop their retiree coverage under the base bill in favor of the plans we offer. CBO estimated the Democratic substitute, too, on that point.

How credible is an argument against the base bill that complains about a potential 30 percent loss of employer coverage when CBO estimates that 100 percent of employers will drop retiree coverage under the Democratic substitute? That all taxpayer dollars will be used to substitute private dollars? And the Medicare system, already crushed and about to go into insolvency, will have to assume all that responsibility, too? If you really believe in Medicare, why would you burden it so? Why would you eliminate private coverage in America, as CBO estimates would happen under the Democratic substitute?

This substitute busts our budget. It purports to provide more drug coverage than the base bill but no reforms, it does not save Medicare; and on top of that it virtually eliminates private retiree coverage in America. Why would we want to go that direction? We rejected that direction during the Clinton years when Mrs. CLINTON presented us with one-size-fits-all health care for all Americans. We recognized then that if you do not have the competitive choices in America in health care, just as we do with so many other services, that things go bad in this country and that sooner or later the crushing weight of benefits added upon benefits added upon benefits means the working people of America have to pay more and more and more taxes. In fact, it is estimated that within 70 years, if we do not begin today making decisions like we ask the House to make, entitlements in America will eat up every tax dollar paid into the Treasury by every citizen in America, and we will have no money for any other function in this country. That is where this substitute takes us, and that is why we need to reject it.

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. My dear friends and colleagues, I lay before you the Republican plan. I ask you to look at it with a straight face, because it is inexplicable, and I cannot explain it to you with a straight face. The amendment which was offered by my dear friend, the gentleman from New York (Mr. RANGEL), on behalf of him and me, does the following things: it gives and sets forth a very clear set of benefits. Senior citizens pay $25 a month; they get 80 percent of drug costs from government after a $100 deductible. This is what you get if you get the Republican plan. But that is not the worst you get. If you are a senior citizen, you fall into a doughnut hole. After you get $2,000 in drugs that you get under the plan, all of a sudden your payments by the government stop; you have to keep on paying premiums, but you get no benefit

until you have got $5,100. They are going to privatize your Medicare in the year 2010. That is pretty bad.

But it is followed by other things: massive subsidies to the insurance companies which commence in 2 years, in 2006. But that is not all. No guarantee as to what it costs you in terms of what you have to pay in the way of premiums, no assurance that you will get any particular level of benefits. The only person who is going to cut a fat hog out of this deal are those goodhearted, flinty-hearted, cold-hearted folk in the insurance business who are going to all of a sudden get a key to the United States Treasury, the right to collect any amount of money they want and to sucker the Secretary of HHS any old way they are minded and to walk home and to pay the money perhaps to the senior citizens but possibly to their shareholders or in dividends or perhaps to pay it in salaries or in bonuses to their corporate officers. That is what you get under the Republican plan. And privatization of Social Security as you know it today.

The Republicans have said that they intend to do away with Social Security. Well, this is what is happening here. The Democratic plan compels the drug houses to negotiate with the Federal Government and the Secretary. The Republicans preclude him by absolutely prohibiting him from negotiating. We do not tolerate under the Democratic plan the Republican opportunity to privatize Medicare. And just wait till your senior citizens find out what you are doing to them with privatization and doing away with fee-for-service and substituting in lieu of this the kind of plan that you talk about where there is no assurance of protection for the senior citizens.

The Republicans say the bill costs too much. Well, it pays some $800 billion to 40 million senior citizens. Just last week, without a gasp of shame, my Republican friends set it up so that 200,000 families got the same amount of money. I think it is time we looked after the senior citizens and not the fat cats that my Republican colleagues and friends look after.

Vote for the Democratic plan. Vote down the Republican plan. Let us take care of the senior citizens. It is the right thing to do.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let us look at the facts behind the rhetoric here. What is going to be the impact of this Democratic substitute on seniors? My colleague from Louisiana just reminded us that 100 percent of employers are going to drop their plans. If there is one thing my senior citizens say to me when I go into senior centers it is, look, help those who need it, but do not destroy my employer-provided retiree plan. Do not touch it. This amendment destroys it, wipes it out. That is not in the interest of your seniors.

But let us look at what it will do to premiums. You were concerned that we did not sock a premium into law. Look what you do in your bill. You sock the premium into law and then you have it rise according to drug inflation. Drug inflation is double-digit. Do you not get it? Those premiums are going to rise steeply. Why would you do that to our seniors?

And let us look at the effect on prices. There is one thing seniors say to you over and over again, the prices are too high. Yet according to Dr. Holtz-Eakin's testimony of April 9, 2003, he says, ''If you subsidize 90 percent of any insurance product versus 70 percent of the product, the larger subsidy will lead to a lower incentive to control costs and will lead to higher prices and higher spending.'' Yours is a giveaway to the pharmaceutical industry. It will drive prices up because there is no incentive for the PBM or the plan to negotiate prices down and they can just pass it on to the government, because we are going to pay it all. Yours is going to drive prices up, premiums up and employer plans out of the market. I do not know why you think you are doing the seniors a good service.

And look at the impact on their kids, because they care about their kids and their grandkids. We have heard testimony over and over again that if you have a 10-year-old child, in 20 years when that kid is 30 and trying to pay back college loans, trying to buy a house, trying to get established, having to buy a car, that child will live in a Nation in which three-quarters of all the Federal revenues will go to Social Security, Medicare and Medicaid.

What is that child to do about education for their children? What is that young person to do to make a living? You shoulder so much debt on the next generation that they will not have public education the way we know it today. They will not have the roads and bridges that a strong economy depends on. They will not be able to defend this Nation in a world that is going to be far more dangerous than the one we have known. This is utterly irresponsible. It is so irresponsible that when the other body proposed this plan in the Senate the last session of Congress, they could not write a budget resolution because they did not know how to handle the extraordinary debt that this creates in the decades ahead.

I urge my colleagues to think that something that looks pretty for your seniors, in fact, will be terrible for their health.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume. I know earlier I moved the distinguished gentleman from Louisiana, the chairman of the Committee on Energy and Commerce, to talk about his poverty and I wanted to join him in that. I too was raised poor. I was raised so poor that I never slept alone until I was married. I want to go on and suggest that I am not going to let you have that field all to yourself.

We have introduced a substitute. Unlike your bill, ours has specific benefits. Your bill, I would remind the gentlewoman from Connecticut, has no benefit in it. It is all estimates. It is all examples. There is no benefit in your bill, and indeed in our substitute there is. You have heard it. It is simple. It is $25 a month, 20 percent coinsurance, no gaps; and we pay out of pocket after $2,000.

Yes, you will say it costs a lot of money. The gentlewoman from Connecticut forgets about the $5.6 trillion surplus that Bush had when he came into office and which he squandered on tax cuts in the meantime. But we do have an income transfer as we have been accused of. It is very simple. You can look at it this way. You have given $800 billion to 10,000 of the richest families each year when you did away with the inheritance tax. No question about it. That is what it costs. Those are the beneficiaries. We would take that money as an alternative and give it to what will be in a short 10 years 100 million seniors. What you have given away to the richest seniors in this country would more than pay for a drug benefit of the magnitude that we offer, a standard Medicare drug benefit, and I suggest that that is a transfer worth making and that that defines the difference between us.

□ 2315

You give $800 billion to 10,000 families a year, the richest in America. We would give that $800 billion to 100 million seniors who needed a drug benefit that they can define, depend on and understand, and that is why the Members should support the Democratic substitute. It is defined. It is real. It solves the problem for seniors, and it is, I think, one of the highest priorities that this House has.

Mr. Speaker, I reserve the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), the chairman of the Oversight and Investigations Subcommittee of the Committee on Energy and Commerce.

Mr. GREENWOOD. Mr. Speaker, I thank the chairman of the committee for yielding me this time.

The gentleman from Michigan (Mr. DINGELL) and others have presented a chart earlier that purported to show that somehow our plan was too complicated. It is a complicated issue to provide prescription drug benefits to millions of Americans who have never had them.

Let me show another chart that describes our plan and it is not complicated at all. Today a senior citizen walks into a drugstore and wants to buy Lopressor, 100 milligrams. She has to pay, for 30 tabs, $45.99 right out of her pocket. Under our bill the price first comes down because of the group purchasing power to $36.79 and then what does she pay? She pays $7.36 and if she is low income she pays $5. That is a big difference from $46.

Let us look at Lipitor. An awful lot of Americans take Lipitor every day to keep their cholesterol down. I do. It costs $108.65 today because for 40 years the Democrats did not do anything about prescription drugs and for 8 years President Clinton did not do anything about prescription drugs, but under our plan Lipitor goes down to $86.92 because of our purchasing power, but the beneficiary pays, his/her share, $17.38. Pretty straightforward. Pretty simple. Nothing complicated about that.

Celebrex, an important anti-inflammatory drug for arthritis that so many seniors suffer from, a very popular drug, $86.28 today to get 30 tablets of that for 1 month. We bring it down to $69.02 because of our power of purchasing, but the beneficiary pays $13.80 for a month's supply and if they are a poor senior citizen, $5. $5, down from $86.28.

Zoloft, 100 milligrams, 30 tabs for a month, it is an antidepressant. A lot of elderly suffer from depression, unfortunately, at their age in part because they do not have good health care. We bring the price down to $63.17. The beneficiary pays $12.63 a month and, if she is poor, $5 a month.

This chart is pretty straightforward and pretty simple. This demonstrates what happens when good-minded people do very hard work with very smart staff, employing very good ideas. We get the job done for the elderly, a job that I am sorry to the gentleman from California (Mr. STARK), I am sorry to the gentleman from Michigan (Mr. DINGELL). They have been here for a long time and they have done nothing. A lot of talk tonight. A lot of good talk, a lot of bogeyman talk, a lot of scare-the-seniors talk tonight, but we will get this done. It will be very simple. It will be very straightforward. The senior citizens will love it, and as a measure of that you are all going to be voting for it next month.

Mr. DINGELL. Mr. Speaker, I yield myself 15 seconds.

I hope my colleagues look at that chart because it has the same factual value as Alice in Wonderland. There is no requirement that any of those drugs be made available. There is no requirement that they be made available at any particular price or that they have to be made available under the plan at any particular cost because of cost sharing with the insurance.

Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, today the House should be considering a Medicare prescription drug benefit for all America's seniors and disabled citizens that would be a benefit that is certain, a benefit that is affordable, and a benefit that helps Medicare beneficiaries with all of their drugs. It should not have large gaps in coverage as the Republican bill does. It should not let private insurance companies charge whatever premium they want and cover whatever drugs they want as the Republican bill does. It should be available in every part of the country, not only in areas where private insurers decide they can make a profit, and it should not cost seniors more if they live in Iowa instead of Virginia or California instead of Rhode Island. Most importantly, it should be a part of the Medicare program, just as dependable as the rest of the Medicare is for seniors and disabled people today.

The Republican bill fails all of these tests. It makes promises on the one hand and then takes them away when we read the fine print. It claims to give special help to America's low-income seniors so that they can afford to pay for the prescription drug program, but then it makes seniors subject to a detailed and invasive assets test before they can get help.

If they have over $6,000 in the bank, they do not get any help. When we figure out what they have got if they count the value of their car and it is worth more than $4,500, and what car is not? They do not get any help. They count the value of the clothes and furniture and appliances if they are worth more than $2,000. They can even count the value of their burial plot if it exceeds $1,500. So instead of making sure people of very modest income who need help to get in, they get the fine print eliminating a lot of these people who should be helped, and it makes all of them go through a demeaning and complex process to prove they have few assets.

All this to get help with their drug expenses. This is just wrong. Instead of spending the public's money to get the best possible drug benefit, this Republican bill spends our dollars to bribe insurance companies to sell a drug plan. It pays for profits for the insurance companies instead of the bills for our seniors.

What we should be doing is using the purchasing power of America's seniors, 40 million of them, to get good prices on their drugs as they do in Canada and get good coverage. That is what the Democratic substitute does. I urge my colleagues to vote for the Democratic substitute and against the Republican bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSLE), a member of the Committee on Ways and Means and esteemed chairman of the Committee on the Budget.

Mr. NUSSLE. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I would like to know where the new Democrat budget hawks are tonight, those new birds who seem to have flown the coop, who have spent the last many months here on the floor talking about the debt tax, something that does not exist but they have sure gotten a lot of ink about it. All sorts of national debt charts have been coming across the floor. In fact, they even one day used the pages, these young high school students, to demonstrate the national debt. But where are they tonight? Where are they when we read the letter from the Congressional Budget Office that says that their so-called substitute would add $1 trillion to the deficit? Where are they? They have flown the coop. We are not hearing about the deficit all of a sudden. In fact, what we heard about is that tax cuts have caused all of the problems.

In fact, one gentleman even had the audacity to stand up and act as though Washington hands money out to people. Tax relief, my friends, is money left in the pockets of people that they earned. We do not hand money out. Money comes from them. And if you are going to waste it on a $1 trillion program, that not only does not fit within the budget that controls tonight but did not even fit within your substitute budget of just 4 months ago.

In fact, if we add the Democrat budget together with the budget that controls today, you bust not only the Republican budget, you bust the Democrat budget, but you bust both budgets combined. That takes a lot of work, to be able to bust both budgets and add $1 trillion to the deficit and have all of these new deficit Democrat hawks whom we cannot find tonight.

It is interesting. Boy, we heard a lot from them all year long, nickeling and diming and worrying about all of that. But when you come to the floor with $1 trillion that says in the same letter that all the employers are going to drop their coverage for retirees, 100 percent are going to drop their coverage, and you have the audacity to present that kind of substitute that busts both budgets, do not come here any more this year and talk about the deficit.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds.

I have the same letter, and it says nothing about employers dropping coverage.

Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT), a member of the Committee on Ways and Means, who understands that spending money to provide a decent drug benefit for seniors is not wasting money.

Mr. MCDERMOTT. Mr. Speaker, Members of the House and those listening to this, I think you ought to take a piece of paper right now and write this down. The premium is $25. The deductible is $100 a year. The coinsurance means you pay 20 percent, the government pays 80 percent for your drugs, and there is a cap on how much you can spend out of pocket, $2,000. That is written into our bill.

In contrast, we have this magic pill that has been given to us where the other side says trust us. Remember, these are the people who told us that there were weapons of mass destruction in Iraq. They were right there. They were going to be delivered in 45 minutes. And, in fact, the President of the United States stood right here and

said, Mr. Speaker, that he believed that they had tried to buy uranium from Niger. It was known that that was a lie. It was known. So now they come out here with this drug bill and they say listen, we think it will be about $35 and maybe you will get this and maybe you will get that, but nothing is written down. I want the people to remember those four things.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair reminds the Member not to make personal remarks regarding the President of the United States.

Mr. TAUZIN. Mr. Speaker, it is almost like Minister of Information Baghdad Bob just arrived here.

Mr. Speaker, I yield myself 2 minutes.

PARLIAMENTARY INQUIRY

Mr. MCDERMOTT. Mr. Speaker, Parliamentary inquiry.

The SPEAKER pro tempore. The gentleman from Louisiana has the floor. Does the gentleman yield?

Mr. TAUZIN. Mr. Speaker, I do not yield.

Mr. MCDERMOTT. Point of personal privilege, Mr. Speaker. Were you making some reference about Baghdad whom? Is that appropriate for the Speaker of the House?

The SPEAKER pro tempore. The gentleman from Washington (Mr. MCDERMOTT) is not in order since the gentleman from Louisiana (Mr. TAUZIN) has the time and such a point may not challenge debate.

Mr. TAUZIN. Mr. Speaker, I want to illustrate one of the real inadequacies of the Democratic substitute. In the main bill we reformed something called average wholesale price. I hope everyone knows what that is. I am going to illustrate it for you tonight. Under average wholesale price systems built into Medicare by the Democratic Party all these years, this is what happens. A person goes in for cancer therapy, a senior citizen, and the doctor needs a drug that costs $10; so the doctor buys a chemotherapy drug for $10. The patient ought to have to pay $2 under that, 20 percent co-pay under law. But that is not what happens. Under the average wholesale price system devised by Democratic administrations in the past under Medicare, this is what happens. The government has a phony average wholesale price posted. It might be $200 for that drug that only costs the doctor $10, and the poor patient has to put up 20 percent, not of the $10 but 20 percent of the $200. The patient puts up $40 for a drug that only costs the doctor $10 when the patient should have put up $2. That is called the average wholesale price system. It is rotten. It stinks. Our bill gets rid of it. And we replace it by reimbursing oncologists in America for not one time what their practice expense really ought to be reimbursed under the law, but we double it.

□ 2330

We give them $430 million, twice what CMS estimates they ought to get.

So we get rid of this stinky system that is charging American seniors 20 percent of phoney prices and costing the government Medicare system tens of times what the drugs are really costing the doctors, and we replace it with a rational, a rational reimbursement system.

Now, the Democrats try to settle that system too. Let me tell my colleagues what they do in their substitute. They substitute this average wholesale price system with a system of reimbursement that, according to CBO estimates, is going to cost $14 billion over 10 years; and it is going to cost seniors another $3 billion of copays. We ought to reject that solution.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, the only thing that stinks here is the Republican bill, and it stinks for a lot of reasons.

First of all, because it is not going to give the seniors any benefit. They are not going to have really any drug benefit whatsoever. It is going to force them into an HMO. They will not have any choice of doctors. And fundamentally, in the end what the Republican bill does is kill Medicare by setting up a voucher system so we do not even have traditional Medicare.

I am sick and tired of hearing my Republican colleagues on the other side criticize traditional Medicare. Medicare is not insolvent. Medicare is a good program. Do not tell me that Medicare is broke or Medicare needs to be fixed. And I say to the gentlewoman from Connecticut, do not insult me and say the Democrats are irresponsible, the Democrats are putting us in debt. The Republicans are the ones that are putting us in debt, because you are borrowing from the trust fund so there is no money left in it because you want to kill Medicare. That is what you are all about.

These gentlemen over here, these Democrats who have been here for a long time, they are here tonight because they want to save Medicare. They understand that Medicare can be helped by putting on a prescription drug benefit, so they look at the tried and true system, they look at what we do in part B for our doctor bills, and they say, yes, let us just add a benefit like part B. We will have a low premium. We will have a low deductible. We will pay 80 percent of the cost on the Federal Government. We will have a catastrophic at 2,000. Just add the tried and true program, like we have in part B, and add a drug benefit. We do not need HMOs. We do not need all of these other gimmicks that the Republicans come up with.

And then these gentlemen, my colleagues, the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL), they say, well, we can pay for this very easily by negotiating the price and giving the Secretary the power to lower the prices. That would cut the program in half. That is what our Democratic leader said. That would cut the cost of the program in half so we would not have to go into debt. We would not have to borrow from the trust fund and make it insolvent, which is what my Republican colleagues have been doing here and what they are proposing.

Mr. Speaker, do not sell out to the HMOs and the insurance companies. That is what you are doing. You are selling out by saying everybody has got to go into an HMO because you are in bed with the insurance companies. You are selling out to the pharmaceutical industry because you want no price reductions, because you are going to get some benefit from the pharmaceutical industry.

And then you come up with: this is complicated. The gentleman from Pennsylvania (Mr. GREENWOOD) said, oh this is complicated. There is nothing complicated here. It is simple. We have had the program for years. We just add the prescription drug benefit, and we have a negotiated price. It is very simple.

Do not give me this chart. I mean, look at this garbage. How could anyone possibly understand it? I cannot even understand it myself, and you expect my mother or somebody's grandmother to understand this thing? You are making it complicated. You are destroying Medicare. Do not insult us as Democrats. We have been out there protecting it for years.

Mrs. JOHNSON of Connecticut. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN), a member of the Committee on Ways and Means.

Mr. RYAN of Wisconsin. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I want to calm down a little bit. There has been a lot of shouting around here, a lot of heated rhetoric, a lot of hyperbole. Let us just look at a couple of facts.

It is a fact that the Medicare actuaries are telling us that Medicare is going insolvent in 13 years. The entire trust fund goes bankrupt in 2036. It is a fact that if we add more money on top of Medicare without doing any reforms, you are going to accelerate the insolvency of Medicare. We can try and speak those facts away, but the fact remains that those are facts.

Now, what this Democrat substitute does is it costs over $1 trillion. It accelerates the bankruptcy of Medicare. The basic assumption in this CBO estimate is that every employer providing private drug coverage for the retirees is going to drop it. And why would they not? Why would they not drop it if the Federal Government is going to pay for it all?

What the facts are is that this plan is going to accelerate the bankruptcy of Medicare.

Now, what are we trying to achieve with the Republican bill? Mr. Speaker, there are parts of this bill that none of us all like. I have my own criticisms. But what we are trying to achieve is not only modernizing this program so it works for today's seniors by giving them cheaper drugs and coverage of drugs, but we are also trying to modernize this program and save it for the baby boom generation.

We have 77 million retirees coming in this country starting in 15 years; and if we accelerate the bankruptcy of this program as the Democrats are proposing to do, it is not going to be there for them.

So what we are doing with these market-based reforms and giving seniors more choices? We are giving them the chance that this program will be solvent for the boomers when they retire. That is the responsible thing to do here. The responsible thing is to make it work for today's seniors, make it modern, make it comprehensive, work on prescription drug prices, work on prescription drug coverage, but give seniors more choices, use competition, use the things that have worked in the past so we can save this program for the baby boomers. That is what the Republican bill does.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds for a couple of housekeeping things.

In 13 years, the revenues start to decline, but it does not go insolvent for 24 years. And I say to the gentleman from Ohio (Mr. NUSSLE), if he has indeed the same letter that we are informed we have from CBO dated June 26, it says nothing in there about employers turning back Medicare, so he either misspoke or made it up, which, in my State, we call telling a lie. Unless he has a different letter, which I am assured by CBO he does not, then he made that up.

Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. MENENDEZ).

Mr. MENENDEZ. Mr. Speaker, I rise on behalf of my 84-year-old mother and millions like her across this country. She worked her entire life in the factories of New Jersey. Today she has Alzheimer's and spends over half of her social security check on prescription drugs. If it was not for my sister and me, she would not be able to live with the dignity she deserves.

Now, this Republican package is wrapped in a label that says, ''I care,'' but when you open it up, it contains nothing more than an empty promise.

Under this Republican plan, which lacks the compassion promised by the President and expected from our doctors, millions of seniors who want to stay in traditional Medicare with their own doctor would essentially be forced into HMOs and left without the choices they deserve. This bill is the road towards privatizing Medicare.

Republicans just cannot help themselves. Once again, they have chosen corporate interests over human interests. America's seniors deserve our respect. They have worked too hard, sacrificed too much to be forced to choose between paying their rent, putting food on the table, and having access to life-enhancing drugs.

Support the Democratic substitute that has a real prescription drug provision under Medicare.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from California (Mr. CUNNINGHAM), our fighter pilot commander extraordinaire.

Mr. CUNNINGHAM. Mr. Speaker, I had pneumonia about 5 years ago, and I went to pick up the prescription drug and I looked at it. It was 120 bucks. As I picked it up, I sat there and I thought, how does a family with three or four children afford 120 bucks per bottle of Augmentin to help them with the flu or with other antibiotics? It is a real fact. It is hard.

But Mr. Speaker, I say to the gentleman from Michigan (Mr. DINGELL), does he know the cost of my prescription drug? It cost me $17. Because my wife worked with the Encinitas school district and she had insurance. That is what we want, is a private-public partnership for those people that cannot afford prescription drugs to help them. Over 1.4 million people in California will have no copay, no cost whatsoever. But it will help them in our bill.

I think that your bill, with its costs, is devastating in the long run. It will not help.

If Democrats can demonize pharmaceutical companies, then what is left? The government. If you can demonize insurance companies, what is left for health care? Government-controlled health care. We rejected that in 1993 when the then First Lady offered it. I oppose government-controlled health care, and maybe that is the difference in us, because it will drive this country in debt.

I talked to some people from Canada. Do my colleagues know where they go to get their health care? They come clear down to Buffalo, New York to get it, because it is so bad with their government-controlled health care.

Let us defeat the Democratic substitute and support the primary bill.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, the Republican prescription drug plan is bad for America and even worse for rural America.

Today I sent around a letter to Members explaining exactly why this GOP bill shortchanges rural areas like Northern Michigan, which I represent.

The Rangel-Dingell substitute ensures that rural areas are treated fairly. The Republican plan continues to put citizens in these areas at a huge disadvantage. The Rangel-Dingell bill goes far beyond the meager provisions for rural health care providers included in the GOP bill. Our bill, the Democratic bill, provides over $10 billion in additional relief for rural areas and removing the harmful Medicare privatization provisions that just have not worked in rural America.

Instead of helping seniors with their prescription drug plan, the Republican plan subsidizes private insurance companies. This plan tends to bribe private insurance companies to provide service in rural districts like mine. These insurance companies have come before our Committee on Energy and Commerce and have testified that they will not be providing the service, and the Republican plan just will not work.

If insurance companies do change their minds, there is nothing in this bill that will prevent them from shifting the added costs to our seniors. I had an amendment in the Committee on Energy and Commerce that would have prevented increases in the monthly premiums for seniors, no matter where they live. But unfortunately, it was voted down on a party line vote.

The GOP plan has a huge gap in coverage and does nothing to reduce the inflated prices big drug companies are charging for prescription drugs. In fact, the Republican plan has a noninterference clause that says the Health and Human Services Secretary will not, will not be allowed to negotiate lower prices for Americans.

The Rangel-Dingell bill will ensure that every senior, regardless of where they live, will be able to obtain the prescription drugs and the quality of health care they require to live a healthy life. This coverage will be provided through Medicare. Democrats are working to strengthen this program, not to do away with it, as the gentleman from California (Mr. THOMAS) called for when he said, and I quote him, ''To those who say the GOP bill will end Medicare as we know it, our answer is: We certainly hope so.'' Thus, the real motive behind the GOP plan is to do away with Medicare. Democrats proudly stand behind Medicare. Support the Rangel-Dingell substitute.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. HAYWORTH), a member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, I thank my friend from Connecticut, and she has visited Arizona, and I know that the hour grows late and the debate grows heated and sometimes well-intentioned efforts from some are thrown in the confusion.

Mr. Speaker, I rise to urge this House to reject the Democratic substitute and to vote ''yes'' for H.R. 1, for reasonable, rational, clear-cut reform of Medicare that will bring Medicare into the 21st century with prescription drug coverage.

□ 2345

Mr. Speaker, we have read even tonight in Europe the development of a

cardiac drug that is estimated to cut heart attacks by 80 percent. We have made great gains in pharmacology; but we do not continue those gains, Mr. Speaker, if we opt for a trillion dollar travesty. And make no mistake, that is what the minority substitute is offering to us this evening.

It was interesting, my friend from Iowa, who pointed out that the deficit hawks on the other sides had flown the coop. It is interesting, so many on the left who are so quick to indict folks higher on the economic scale tonight are strangely silent when we offer a plan where we give the priorities to those who need the help first.

The irony is, my friends on the left in the trillion dollars travesty section say, do not worry. Let us break the bank. Let the good times roll. Take command and control, put it together with a trillion bucks. No worries. But we know what would happen under that plan. It is a prescription for bankruptcy. And it is a prescription to mortgage the future of the working families that my friends purport to support.

People of good will can have different opinions, and we certainly have them here in the House tonight. The question often comes down to this, when is enough enough? With the left it is never enough.

Reject insanity. Vote for rationality, ''yes'' to H.R. 1; ''no'' to the Democratic substitute.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair would remind Members of the time remaining. The gentleman from Louisiana (Mr. TAUZIN) has 4½ minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 3½ minutes remaining and would be next in line to close. The gentlewoman from Connecticut (Mrs. JOHNSON) has 5½ minutes remaining and would be the second to close. The gentleman from Michigan (Mr. DINGELL) has 4¼ minutes remaining and would be the first to close.

The Chair recognizes the gentleman from California.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. KUCINICH).

Mr. KUCINICH. Mr. Speaker, everyone in America knows the price of drugs is too high. Seniors know it best. Proponents of H.R. 1 are not representing the seniors of America. They represent the biggest campaign contributors in America, the private health insurance industry led by drug makers.

The Rangel-Dingell substitute will bring down the cost of the drugs. It allows Medicare to buy drugs in bulk and negotiate for lower prices, which the VA already does. Skyrocketing drug costs are not only driving up health care expenses but are causing seniors to make cruel choices between prescriptions and food, prescriptions and clothing. Some seniors are even splitting pills to make prescriptions last.

Seniors are crying out for help, but their pleas are drowned out by the cash registers humming away at the majority party headquarters, while insurance and pharmaceutical company lobbyists rush to the great Medicare sellout event.

Yes, some of our friends are indeed trying to take care of people in their old age. Themselves.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I want to point out that despite what you may have heard on the floor tonight, our basic package contains $27.2 billion of assistance to rural health care. That is the largest package of rural health care we have ever voted on all the times we have voted on Medicare prescription drugs.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. UPTON), the chairman of the Subcommittee on Telecommunications and the Internet of the Committee on Energy and Commerce.

(Mr. UPTON asked and was given permission to revise and extend his remarks.)

Mr. UPTON. Mr. Speaker, I have heard a lot of criticism tonight about this drug bill; and I want to remind all of us as we go back to our districts, as we have heard for so many years at our town meetings and so many events, America wants and needs a prescription drug program for our seniors. I remind all of our colleagues here tonight that this program is voluntary. You do not have to participate if you do not want to, but for many Americans they will want to participate. They are going to participate.

Mr. Speaker, I want to relate a little story that happened to me in my district last summer. I was at my son's little league game. A woman ran up to me as I was getting in my car and packing up the gear. She said, My mom just had a stroke. It will cost her $600 a month to survive. We never had that in our budget. We cannot afford it. Is the plan that you passed last week, this was last year, is that going to help my mom? I put my hands on her shoulders and I said, Yes, I believe that it will. She will be able to benefit from this plan. You will be able to use the assets that you have and to have her survive in a meaningful way.

Yet, the other body never came back. The other body never came back with a plan and, in fact, that woman and her family were very distraught.

This is a plan tonight that can pass with bipartisan support, not only in this Chamber but the other Chamber on the other side of the Capitol. The President will sign this bill. It is within the budget. No, it is not perfect. But we can take a step to help the woman that I had talked to last year as well as the thousands of people that have come to our town meetings over the course of the last number of years.

Mr. Speaker, I urge my colleagues to defeat the Democratic substitute and, yes, support this plan that we take up a little bit later this morning.

Mr. DINGELL. Mr. Speaker, I yield 2¼ minutes to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, once upon a time in 1989, a group of very angry seniors chased their Congressman, the powerful chairman of the House Committee on Ways and Means, into his car because they wanted him to know that they did not like the catastrophic health care bill.

This happens to be the picture that appeared on the front page of the Chicago Tribune in August of 1989. This was a bill that passed this body with overwhelming bipartisan support and all of the national senior citizens organizations supported the bill. There was only one problem. No one had checked in with rank-and-file seniors around the country who sat down with their calculators and they figured out what the benefit would be that they would get and how much it would cost them, and they did not like the answer.

Now, I show you this photo not to revive the debate on catastrophic because within a couple of months the bill was repealed, something very unusual and usually very difficult. I show you this photo as a friendly warning. If you pass H.R. 1 tonight, you better also go out and buy some running shoes because senior citizens are too smart to be fooled by Republican speeches or anybody else's speeches. They will figure out on their own what this bill does, which is, as the current chairman of the powerful House Committee on Ways and Means hopes, destroy Medicare as we know it.

Seniors will get out their calculators and figure it out.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Ohio (Mr. PORTMAN).

Mr. PORTMAN. Mr. Speaker, it has been a very interesting debate, too, as you listen to this debate tonight. We had 3 hours of good debate on the Republican legislation, the underlying bill which provides historic prescription drug coverage and does so within the budget. Now is the opportunity for the Democrats to talk about their substitute. So what is your idea? And you know what we are having? More discussion of the underlying legislation. Again, historic legislation to add prescription drug coverage that is within the budget.

The Democrats are not talking about their bill. It adds $1 trillion to the deficit. That busts our budget. It busts their budget. In fact, it busts both budgets combined.

The Democrat legislation does so by loading up the bill, not by helping those seniors who need it the most. The underlying legislation provides for about 30 percent of the seniors that need it most, those under 150 percent of poverty, no deduction, no deductible, no cost sharing, a simple copay when you go to the pharmacy, total subsidy for the prescription drug coverage. Instead, the Democrat plan by going to a

trillion dollars would provide coverage for those who do not even need it. It sounds like what they accuse Republicans of.

I was really interested to see, when you look at page 12 of the Democrat bill, there is also something else interesting. They say we do not provide guaranteed access. We do provide guaranteed access. The government actually steps in when there are not plans available, negotiates down the risk which assures coverage.

If you look at page 12, what does the Democrat plan do? It says, ''The Secretary shall develop procedures to ensure coverage.''

That will give you some comfort. I can see why they are not talking about their legislation. I would not either. Vote for the underlying bill. Vote down this substitute that they will not talk about.

Mr. STARK. Mr. Speaker, I yield myself 1½ minutes.

Mr. Speaker, just to straighten out some of the figures, the Republicans do indeed add $26.7 billion for rural providers. We add $39.1 billion for rural providers. That is $2.5 billion more, and I would hope that the Republicans are not lying to the seniors.

You can lie to us because we are used to it. The White House has set the tone for that. But do not lie to the seniors. There is nothing in your bill. I say to the gentleman from Ohio (Mr. PORTMAN), there is nothing in your bill that guarantees anything, and to say that to the seniors is lying to them.

There is nothing in your bill that guarantees a thing to the seniors and you know it. And if you do not know it, read it again. Otherwise, you are lying to the seniors.

Our bill provides a Medicare benefit which is definable. Yours does not. You do not require any benefits if no insurance company steps up to the plate and there is nothing that requires it. There is not one line in your bill that requires an insurance company to provide anything. So it is all a fantasy. At least we are requiring the government to provide a benefit to the seniors in the same manner they are now familiar, under Medicare with a determined premium, a determined deductible, determined benefits, the same across the country. None of that is available through the Republican bill. To tell the seniors otherwise is lying. You have lied to us tonight and stop lying to the seniors. So support our substitute and vote down the great Republican lie.

Mr. DINGELL. Mr. Speaker, I have an inquiry as to time first before I yield the balance of my time. I believe the gentlewoman from Illinois (Ms. SCHAKOWSKY) did not get the full 2¼ minutes that I yielded to her. I would like to know how much time I have left and how much I can properly yield the gentlewoman from Illinois.

The SPEAKER pro tempore. The gentleman from Michigan has 3 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me time.

Again, this is just a warning, a friendly warning to you that if you pass H.R. 1 tonight, you better also go out and get your running shoes because the seniors are too smart to be fooled by your proposal. And you can trash Medicare all you want. You can call it an outdated program, antiquated; but I do not know who you are talking to.

I do believe that you love your mothers, but it is obvious to me that you do not call them enough. You do not go to senior centers enough. Not the ones I have gone to in my 5 years as director of the State Council of Senior Citizens. Seniors love their Medicare. The only thing they do not like is that it does not cover prescription drugs. And that is why if you are smart or out of shape and not able to be chased by seniors, you will vote for the Rangel-Dingell substitute.

The Democratic substitute is what seniors have been asking for and what every politician has been promising them, an understandable, defined, dependable Medicare prescription drug benefit. It has all the features of Medicare that our seniors know and love, a set premium, no copayments.

Vote for the substitute or start running.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Virginia (Mr. TOM DAVIS).

Mr. TOM DAVIS of Virginia. Mr. Speaker, I would like to engage in a colloquy with my colleague.

Can she confirm that the language in H.R. 1 includes plans under the Federal Employee Retirement Plan as an employment base plan?

□ 0000

Mrs. JOHNSON of Connecticut. Mr. Speaker, will the gentleman yield?

Mr. TOM DAVIS of Virginia. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Speaker, yes, that is correct.

Mr. TOM DAVIS of Virginia. This will allow OPM to take advantage of the subsidies in the bill just as other employees and unions will?

Mrs. JOHNSON of Connecticut. That is correct.

Mr. TOM DAVIS of Virginia. Mr. Speaker, I appreciate the gentlewoman's and the chairman's willingness to work with us on this issue. I think that allowing the subsidies H.R. 1 provides for will result in lower premiums and improved benefits for all FEHBP enrollees.

Mrs. JOHNSON of Connecticut. I thank the gentleman, and I look forward to working with the gentleman on this issue as the bill moves to conference.

Mr. TOM DAVIS of Virginia. Mr. Speaker, as I said, I appreciate the willingness of the gentlewoman to clarify that.

I have another concern, that Federal employees are often treated differently from current Federal employees in ways that are not always equitable. Retirees are different from current Federal employees. For example, current employees are allowed to pay their health insurance premiums from pre-tax dollars. Federal retirees are not.

FEHBP currently does not provide different benefits for retirees and current employees. One is simply a member of FEHBP. I think it is important that this dynamic remain once a Medicare prescription drug benefit is put into place, whichever plan passes.

As chairman of the Committee on Government Reform, I look at this from an employer's perspective. We do not want private employers to drop the prescription drug coverage they provide for their retirees. H.R. 1 provides incentives so that they will not do so, but we as the Federal Government have to lead by example.

I have introduced legislation that simply states that Federal retirees will continue to be treated on par with current Federal employees when it comes to prescription benefits. I regret we were unable to include this language in H.R. 1, but I am grateful to have the commitment of the Speaker and the majority leader to bring this bill to the floor as soon as we return from recess.

Mr. TAUZIN. Mr. Speaker, may I inquire how many minutes are left for each one of the four who have allocated time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 2 minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 1 minute remaining and would be next to close. The gentlewoman from Connecticut (Mrs. JOHNSON) has 2½ minutes remaining, and the gentleman from Michigan (Mr. DINGELL) has 2 minutes remaining.

Mr. TAUZIN. Mr. Speaker, we reserve the balance of our time. If anyone wants to use some more time at this time would be a good time to do it.

Mr. DINGELL. Mr. Speaker, I reserve the balance of my time, and I want to yield it to our leader.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 30 seconds.

This is a historic evening. It is our opportunity tonight to provide prescription drugs to all seniors under Medicare as an entitlement and to do it in a way that is fair, simple and generous and sustainable. It is our opportunity tonight to modernize the benefit program under Medicare to deal with chronic care for our seniors, a big concern for them, and to structure Medicare in such a way that it will be sustainable, the dollars will be there and Medicare will be able to provide the health retirement security in the future that it has in the past.

I urge support of H.R. 1 and defeat of the substitute.

CALL OF THE HOUSE

Mr. TAUZIN. Mr. Speaker, I move a call of the House.

The SPEAKER pro tempore. A quorum is not present.

A call of the House was ordered.

The call was taken by electronic device, and the following Members responded to their names:

[Roll No. 329]

ANSWERED ''PRESENT''—421

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velazquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). There are 2 minutes remaining in this vote.

□ 0022

The SPEAKER pro tempore. On this rollcall, 421 Members have recorded their presence by electronic device, a quorum.

Under the rule, further proceedings under the call are dispensed with.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) is recognized.

Mr. DINGELL. Mr. Speaker, I yield the balance of my time to the distinguished gentleman from Arkansas (Mr. BERRY).

The SPEAKER pro tempore. The gentleman from Arkansas is recognized for 2 minutes.

Mr. BERRY. Mr. Speaker, we are here this evening on a very serious matter. It can literally mean life or death for many of our elderly citizens. Our great Nation was founded, and has so far been successful, based on the self-evident truth in the Declaration of Independence that all men are created equal. They are endowed by their Creator with certain inalienable rights, and that among these are life, liberty, and the pursuit of happiness.

Mr. Speaker, these founding truths were followed by a firm commitment from our Founding Fathers, the last sentence in the Declaration of Independence. It says: In support of this declaration, with a firm reliance on the protection of Divine Providence, we mutually pledge to each other our lives, our fortunes, and our sacred honor.

Mr. Speaker, I think that those men would be heartbroken to see what happens here this evening. As I said earlier, the Republicans are in charge. We recognize that. You can do what you want to do. You do, and I give you credit, for publicly acknowledging that you want to destroy Medicare. You do, and I give you credit, for some of your leaders publicly acknowledging that you would put us into bankruptcy just so we can make the government smaller, so we can do away with certain social programs that you do not like. And I give you credit for that. In fact, I think some of you, and I have seen it, have publicly proclaimed you are proud of it.

My dilemma is, why would you want to do what you are trying to do tonight to the greatest generation, the men and women that went through the Depression, fought World War II, and then built this great Nation into what it is today and turned it over to my generation?

I had a cute little remark in there, but I am not going to use it because I think this is far too serious, this business we take up this evening. A government should not make poor people poorer, rich people richer. It should not create a situation where no one has to be responsible, and it should not make it possible for a person or group of persons to be able to take advantage of others because of an act of that government.

If you do what you are talking about doing, you will make that exact thing possible. You will make it possible for insurance companies and pharmaceutical companies to rob the senior citizens of this country.

The SPEAKER pro tempore. The gentlewoman from Connecticut (Mrs. JOHNSON) is recognized.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield the balance of my time to the gentleman from Texas (Mr. DELAY), the majority leader.

Mr. DELAY. Mr. Speaker, I want to commend all those that have worked so hard on probably the most important issue that most of us will vote on in our career. There is very few times that you are going to have a vote like this.

□ 0030

Mr. Speaker, the gentleman from California (Mr. THOMAS), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Louisiana (Mr. TAUZIN), the members of the Committee on Ways and Means, members of the Committee on Energy and Commerce, Members know this is incredibly important. The future of our seniors, the future of our children are at stake.

Yogi Berra said when you reach a fork in the road, take it. That is sort of where we are tonight, at that fork in the road. Many of us want to take it because we know, we have witnessed Medicare being a system at the present time that is a disaster waiting to happen.

We are spending $267-plus billion a year on Medicare. Payroll taxes only pay 57 percent of that, general revenue and other taxes pay 30 percent, and premiums pay 10 percent. In less than 20 years, the payroll taxes will only cover 30 percent, the rest will come from our children and their incomes. That is on top of the fact that there is over $13 trillion in unfunded liability. In just 5 years, we will be spending over $400 billion per year on Medicare. Now some on my side of the aisle think $400 billion is a lot of money over 10 years, and giving this benefit is really expensive.

But at the same time what are we getting for this system that has been designed to bankrupt this country? What we are getting is doctors refusing to take seniors as patients. We have hospitals closing. We have costs escalating through the roof. Medicare is driving other health care costs through the roof. Seniors are having to make spending decisions based upon the cost of their health care or their drugs. This is the system they want to preserve. This is the system that they want to see continue. But many of us, both Democrats and Republicans, think that this is a time that we have an incredible opportunity.

I came here to make a difference; and, frankly, since this Republican House has been in the majority we have made an incredible difference. Some Members wanted to preserve the old welfare system. We reformed welfare. Some of our Members have commented over the last few days that entitlements are forever. No, they are not. Welfare was an entitlement, and we changed it. We stood up and led and took the responsibility to do so. Tax relief, tax reform, paying down the debt, not one time in 40 years did the other side of the aisle balance the budget, we did. They spent 40 years driving up the debt on our children, we paid over $550 billion on that debt.

So what are we faced with on this road that forks? What is the solution? The Democrats have offered their solution, and I say to Members, we get a glimpse of the future. I hope Members watched the debate on their substitute because that is a glimpse of the future if this bill does not pass.

Let me tell Members what people have said about their substitute. According to Tom Saving, who is a current Medicare trustee, the Democrat plan would lead to Medicare consuming not only all of the Medicare payroll taxes, but also more than 54 percent of all Federal income taxes by the year 2040 and over 90 percent of all Federal income taxes by the year 2075. They want to continue the plan. The Democrat plan would add between $18 trillion and $30 trillion in unfunded liabilities to the Federal Government's balance sheet. They want to preserve Medicare, and that is what it would be.

Now what is the Senate's solution? More of the same. The Senate is writing a bill over there that Senator KENNEDY is very proud of. Well, the Senate has got to do what it has got to do.

What is our solution? It has been talked about over and over again, but what we are desperately trying to do is bend that growth curve and get a handle on this and still bring good quality health care to our senior citizens by bringing market forces into play, by addressing the third party payment problem through copayments, deductibles and so forth, but give seniors the right to choose the type of health care that they think is best suited for their needs, not what some government program tells them is going to suit their needs.

We want to start us down that fork to make Medicare a viable, reliable program for generations to come. I just ask my colleagues and Democrats to vote no. What is the alternative if this bill does not pass tonight? What is the alternative? I do not know the answer to that question. I have asked that question for the 6 months that we have been working on this piece of legislation. I do not know what the alternative is, but I do know we have an opportunity.

Mr. Speaker, sometimes things are not the way you want them to be. Sometimes a bill does not have quite as many reforms as Members want. This bill does not have as many reforms as I would like to see, but it is starting us on a different path, a path of fiscal responsibility, a path that provides quality health care to our seniors, provides them choice.

A study was just done. They claim that all these private plans will not work. Our own plan, FEHBP, has been growing at a slower rate than the Medicare plan. That ought to tell Members something, when there is competitiveness in the process, costs are held down and quality is increased.

Let me tell Members, this is the beginning of something that we can be proud of. It may not be the end. We may have to change it down the line, but we need the opportunity to move this forward so we can provide a future for our children that brings sanity to this process. That is why we came here, to bring sanity to this process. I urge all Members on both sides of the aisle to join us because Medicare is too important for partisan politics.

Mr. Speaker, the American people have asked us for this. They sent us here to do this, and they deserve this approach. It is the right thing to do. It is the right time to do it, and if we fail to act now, we may never have another chance to make it right. The American people have given us this opportunity to lead; and in leadership, responsibility has to be there. We are ready to stand up and lead, and it is our job to seize that opportunity today. I just ask Members, I implore Members to vote yes for Medicare, vote yes for our seniors, vote yes for this bill.

Mr. STARK. Mr. Speaker, I yield the balance of my time to the gentlewoman from California (Ms. PELOSI), the minority leader.

Ms. PELOSI. Mr. Speaker, the distinguished majority leader who just spoke said something that I agree with. He said that this issue that we are voting on tonight is probably one of the most important issues we will vote on in our career. Mr. Leader, I quite agree.

Mr. Speaker, that is why it is hard to understand why we are taking up this debate in the dark of night when the Senate has taken up the bill for 2 weeks with the consideration of 30 amendments, to have a free and open exchange of ideas about this most important issue in our careers. And when the bill was sent to the floor in this House of Representatives for this most important issue, no amendments were allowed. Why were they not allowed, because of the fear that they might have passed and improved this Republican bill on the floor which dishonors the seniors that it pretends to support and dishonors the people who sent us to this House of Representatives by not allowing their amendments to be heard on this floor.

My leadership role afforded me the opportunity to speak at some length earlier about my concerns about the Republican bill and my preference for the Democratic bill. I had only intended to take one moment to close, but after hearing my colleagues talk about fiscal responsibility, I cannot resist the opportunity to state the facts because it is one of the mysteries of this floor, that Members can come to the floor and misrepresent the facts, and that is in order, but to call them on it is out of order. But I am going to take that risk.

The fact is that under the Clinton administration and the legislation passed in this House with 100 percent of the Democratic votes and not one Republican vote, coming out of the Clinton years we were on a path of $5.6 trillion in surplus, in surplus. In the 2½ years in the Bush administration, we are now on a path going to $3 trillion in deficit, a swing of over $8 trillion onto the national debt, and they call that fiscally sound, as they give away huge tax cuts to the 200,000 wealthiest families in America, and many of us in this room are part of that and would benefit, but not in the enlightened self-interest of this country. But for that same money,

every senior citizen in America could have a real, guaranteed, defined prescription drug benefit.

Mr. Speaker, I want to make two more points. We have had some debate; unfortunately, none of our amendments were we allowed to bring to the floor. It is late, and we usually do these things in the dark of night so the American people cannot see and cannot have the bright light of day on the debate on this floor to see what is happening to them and to their futures.

□ 0045

But I want to make just two points about the bills. The Democratic bill is a defined guaranteed benefit under Medicare. The Republican bill is not. I heard the distinguished chairman of the Committee on the Budget speak about the cost of the Democratic bill. The Democratic bill cost would be in half if the Republicans would allow the Secretary of HHS to negotiate for best prices. That provision is in the Democratic bill. It makes sense, right? Forty million seniors, lots of purchasing power, lots of leverage. It makes sense. Not to the Republicans. Their bill has a prohibition on the Secretary negotiating for best prices. A prohibition.

I think there are many questions about the Republican bill. It is very complex. But as seniors look at it and they ask those questions, I think there is one question that every American should have: Why do the Republicans have a prohibition on the Secretary negotiating for the best possible price, reducing the cost of prescription drugs to seniors and to the American taxpayer? Why? I will tell you why. Because tonight we have a debate between the special interests and the public interest. The Democrats have come to this floor as servants of the people. The Republicans have come to this floor as handmaidens of the prescription drug industry.

I urge my colleagues to support this amendment and oppose the Republican bill.

Mr. TAUZIN. Mr. Speaker, in order to close this historic debate, I yield the balance of my time to the gentleman from Illinois (Mr. HASTERT), the distinguished Speaker of our whole House.

Mr. HASTERT. Mr. Speaker, the hour is late. We have had a lot of rhetoric. We have had a lot of flailing of arms and pointing fingers across the aisle. It is time for us to come to a reasoned decision. It is time for us to look at all the debate that we have had, to look at the facts. I guess I could be suckered into a debate about fiscal responsibility over the past years, votes we have had and votes we did not have. But the fact is we have a very important bill on the floor of this House tonight, a bill that probably will reach into every American household and give people decisions and benefits on how they are going to take care of their mothers and their fathers and the elderly people that they hold dear.

I want to salute those folks who worked hard on both sides of the aisle to carry on this debate. I thank the gentleman from California (Mr. THOMAS) and the gentleman from Louisiana (Mr. TAUZIN). I am grateful for their hard work. I have worked on health care issues in this Congress for more than a decade. When you compare me to the great gentleman from Michigan, that is probably not very much time. But Bob Michel put me on Mrs. CLINTON's health care task force back in 1993 and Newt Gingrich asked me to deal with the issue of health insurance portability in 1995 and we did that. In every Congress that I have presided as Speaker, this House has passed a prescription drug benefit as part of an effort to modernize Medicare. Today, we have a chance to take a most dramatic step in health care reform, the most dramatic step we have taken in 25 years.

Some of my friends on the other side of the aisle say that we do not spend enough. That is not surprising, because they think that $1 trillion over $400 billion is better over a 10-year period of time. Some of my friends on this side of the aisle believe we spend too much. That is not surprising, either, given their philosophical beliefs. But this bill spends what we can afford to spend. We cannot afford to ignore this issue this year. We on both sides of the aisle have held out a promise to America's seniors that we will give them an opportunity to have a prescription drug benefit and a new modern Medicare. Ladies and gentlemen, we hold out this promise. Tonight is the night that we have an opportunity to fulfill that promise.

In a sense, this is the best of times and the worst of times when it comes to health care in this country. We have the finest doctors. We have the best hospitals. We have people who are uninsured. But we also have the cutting-edge issues and lifesaving prescription drugs. We also have skyrocketing costs. And we have too many people who are uninsured. And we have drugs that for some folks are just too expensive. Last week, we passed legislation to deal with the uninsured when we passed association health plans. Today we deal with the cost issues of health care. Earlier today we passed a health savings account bill which puts the consumer in the driver's seat in driving down costs. And now, in this bill, we make Medicare work better for senior citizens. A Medicare program that does not include a prescription drug benefit is not serving America's seniors well.

When Medicare was first conceived in the 1960s, it was at its heart a program with the costs of going to hospitals and going to doctors. Back then, prescription drugs were not used to the extent they are today. You got an aspirin once in a while, but they just did not play the role they play today. Today because of advancements made over the last 30 years and the R&D we have done in this country, we have drugs that help us stay out of the hospital, we have drugs to help with cholesterol, we have drugs that help us with diabetes, with arthritis, with high blood pressure, on and on and on. And there are lifesaving drugs.

Seniors should have better access at a better price to these drugs through the Medicare system. This bill makes that happen. It will cut drug costs by an average of 37 percent for the average senior. It also includes catastrophic coverage so that no senior with high drug costs will be forced into bankruptcy. This is a compassionate program for senior citizens.

This bill also includes conservative reforms to make sure that Medicare stays solvent. We cannot allow the Medicare system to continue to grow so large that it actually bankrupts this country. We must introduce market-based reforms that lead to greater choices for seniors and greater competition among providers. I agree with the proposition that an 80-year-old grandmother should not be forced into a PPO simply because she gets a prescription drug benefit. But I also agree that a 50-year-old father who has health care choices throughout his whole working career will feel comfortable shopping around for the best health care plan for his individual needs when he qualifies for Medicare. Competition, choice, the marketplace, these are the concepts which will save Medicare for the coming decades.

Mr. Speaker, I urge my colleagues on both sides of the aisle to support this bill. This is a defining moment for this Congress. It is too late for obstruction. It is too late for nit-picking. It is too late for all the lame excuses that we often hear. Senior citizens will long remember if you voted for them today, but they will never forget if you voted against them.

Ladies and gentlemen, not many times in this great hall do we have a piece of legislation when all the forces come together and we have an opportunity to make real change. We have that opportunity tonight. I ask you to vote to provide senior citizens with a better Medicare system and a real prescription drug benefit.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). All time for debate has expired.

Pursuant to House Resolution 299, the previous question is ordered on the bill and on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL).

The question is on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL).

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. RANGEL. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 175, noes 255, answered ''present'' 1, not voting 4, as follows:

[Roll No. 330]

AYES—175

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Boswell
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Clay
Clyburn
Conyers
Cooper
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Doyle
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larson (CT)
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sanchez, Linda T.
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Solis
Spratt
Stark
Strickland
Stupak
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOES—255

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Case
Castle
Chabot
Chocola
Coble
Cole
Collins
Costello
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (FL)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Dooley (CA)
Doolittle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hobson
Hoekstra
Hooley (OR)
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Larsen (WA)
Latham
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (OK)
Manzullo
Marshall
Matheson
McCotter
McCrery
McHugh
McIntyre
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moore
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Sabo
Sanchez, Loretta
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Souder
Stearns
Stenholm
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Udall (CO)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

ANSWERED ''PRESENT''—1

Baird

NOT VOTING—4

LaTourette
McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 0112

Messrs. BACHUS, COSTELLO, and LIPINSKI changed their vote from ''aye'' to ''no.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. THOMPSON OF CALIFORNIA

Mr. THOMPSON of California. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. THOMPSON of California. Yes, I am, Mr. Speaker, in its present form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

MOTION TO RECOMMIT WITH INSTRUCTIONS

Mr. THOMPSON of California moves to recommit the bill H.R. 1 jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with the following amendments:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Prescription Drug and Medicare Improvement Act of 2003''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICAREADVANTAGE PROGRAM

''SEC. 1860D. (a) DEFINITIONS.—In this part:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Center for Medicare Choices as established under section 1808.

''(2) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section; or

''(iii) insulin described in subparagraph (C) of such section;

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B, but shall be so considered if such payment is not available under part A or B because benefits under such parts have been exhausted.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully resolved under subsection (d) or (e)(2) of section 1860D–5.

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A Medicare Prescription Drug plan or a MedicareAdvantage plan may exclude from qualified prescription drug coverage any covered drug—

''(i) for which payment would not be made if section 1862(a) applied to part D; or

''(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–5(e).

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A and enrolled under part B.

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Administrator determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Drug plan, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) any other risk-bearing entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 1860D–6(c)(3), or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

''(6) MEDICAREADVANTAGE ORGANIZATION; MEDICAREADVANTAGE PLAN.—The terms 'MedicareAdvantage organization' and 'MedicareAdvantage plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to MedicareAdvantage organizations).

''(7) MEDICARE PRESCRIPTION DRUG PLAN.—The term 'Medicare Prescription Drug plan' means prescription drug coverage that is offered under a policy, contract, or plan—

''(A) that has been approved under section 1860D–13; and

''(B) by an eligible entity pursuant to, and in accordance with, a contract between the Administrator and the entity under section 1860D–7(b).

''(8) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860D–25) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(9) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' means the coverage described in section 1860D–6(a)(1).

''(10) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' means the coverage described in section 1860D–6(c).

''(b) APPLICATION OF MEDICARE ADVANTAGE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a Medicare Prescription Drug plan and an eligible entity, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a MedicareAdvantage plan included a reference to a Medicare Prescription Drug plan;

''(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

''(4) any reference to part C included a reference to this part.

''Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

''ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''SEC. 1860D–1. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—The Administrator shall provide for and administer a voluntary prescription drug delivery program under which

each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

''(A) MEDICAREADVANTAGE ENROLLEES RECEIVE COVERAGE THROUGH MEDICAREADVANTAGE PLAN.—

''(i) IN GENERAL.—Except as provided in clause (ii), an eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization shall receive coverage of benefits under this part through such plan.

''(ii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE MSA PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in an MSA plan under part C shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'MSA plan' has the meaning given such term in section 1859(b)(3).

''(iii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in a private fee-for-service plan under part C shall—

''(i) receive benefits under this part through such plan if the plan provides qualified prescription drug coverage; and

''(ii) if the plan does not provide qualified prescription drug coverage, receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'private fee-for-service plan' has the meaning given such term in section 1859(b)(2).

''(B) FEE-FOR-SERVICE ENROLLEES RECEIVE COVERAGE THROUGH A MEDICARE PRESCRIPTION DRUG PLAN.—An eligible beneficiary who is enrolled under this part but is not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

''(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(3) SCOPE OF BENEFITS.—Pursuant to section 1860D–6(b)(3)(C), the program established under this part shall provide for coverage of all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes).

''(4) PROGRAM TO BEGIN IN 2006.—The Administrator shall establish the program under this part in a manner so that benefits are first provided beginning on January 1, 2006.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(1)(F)), such beneficiary—

''(1) may continue to receive such coverage and not enroll under this part; and

''(2) pursuant to section 1860D–2(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

''(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT UNDER PROGRAM

''SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

''(1) PROCESS SIMILAR TO PART B ENROLLMENT.—The Administrator shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

''(2) CONDITION OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive access to qualified prescription drug coverage.

''(b) SPECIAL ENROLLMENT PROCEDURES.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) INCREASE IN MONTHLY BENEFICIARY OBLIGATION.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1860D–17 applicable to such beneficiary by an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

''(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

''(ii) BENEFICIARY MUST INVOLUNTARILY LOSE COVERAGE.—Clause (i) shall only apply with respect to coverage—

''(I) in the case of coverage described in clause (ii) of subparagraph (F), if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f));

''(II) in the case of coverage described in clause (i), (iii), or (iv) of subparagraph (F), if the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage; or

''(III) in the case of a beneficiary with coverage described in clause (v) of subparagraph (F), if the issuer of the policy terminates coverage under the policy.

''(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

''(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—Subject to subparagraph (G), for purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(i) DRUG-ONLY COVERAGE UNDER MEDICAID.—Coverage of covered outpatient drugs (as defined in section 1927) under title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.

''(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)).

''(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

''(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

''(v) PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)).

''(G) REQUIREMENT FOR CREDITABLE COVERAGE.—Coverage described in clauses (i) through (v) of subparagraph (F) shall not be considered to be creditable coverage under this part unless the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

''(H) DISCLOSURE.—

''(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (ii) (iii), (iv), or (v) of subparagraph (F) shall provide for disclosure, consistent with standards established by the Administrator, of whether the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

''(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the application of subparagraph (G) if the individual establishes that the individual was not adequately informed that the coverage the beneficiary was enrolled in did not provide the level of benefits required in order for the coverage to be considered creditable coverage under subparagraph (F).

''(2) INITIAL ELECTION PERIODS.—

''(A) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—In the case of an individual who is an eligible beneficiary as of November 1, 2005, there shall be an open enrollment period of 6 months beginning on that date under which such beneficiary may enroll under this part without the application of the late enrollment procedures established under paragraph (1)(A).

''(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who becomes an eligible beneficiary after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—

''(A) ESTABLISHMENT.—The Administrator shall establish a special open enrollment period (as described in subparagraph (B)) for an eligible beneficiary that loses creditable prescription drug coverage.

''(B) SPECIAL OPEN ENROLLMENT PERIOD.—The special open enrollment period described in this subparagraph is the 63-day period that begins on—

''(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the later of the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan or the date the beneficiary is provided with notice of such termination or reduction;

''(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the later of the date on which the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage or the date the beneficiary is provided with notice of such loss of eligibility; or

''(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the latter of the date on which the issuer of the policy terminates coverage under the policy or the date the beneficiary is provided with notice of such termination.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) OPEN AND SPECIAL ENROLLMENT.—

''(A) OPEN ENROLLMENT.—An eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2006.

''(B) SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(3) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(3) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2006.

''(d) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PART A OR B.—

''(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Administrator shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if earlier) under part B.

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Administrator shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a Medicare Prescription Drug plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(1)).

''ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860D–3. (a) IN GENERAL.—

''(1) PROCESS.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Administrator shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization—

''(I) shall make an election to enroll in any Medicare Prescription Drug plan that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and

''(II) may make an annual election to change the election under this clause.

''(ii) CLARIFICATION REGARDING ENROLLMENT.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in any Medicare Prescription Drug plan that has been designated by the Administrator in the area. The Administrator shall establish a process for designating a plan or plans in order to carry out the preceding sentence.

''(B) REQUIREMENTS FOR PROCESS.—In establishing the process under subparagraph (A), the Administrator shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a MedicareAdvantage plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of section 1851(g) (other than clause (i) and the second sentence of clause (ii) of paragraph (3)(C), relating to default enrollment); and

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

''(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT.—The process developed under paragraph (1) shall ensure that eligible beneficiaries who enroll under this part during the open enrollment period under section 1860D–2(b)(2) are permitted to elect an eligible entity prior to January 1, 2006, in order to ensure that coverage under this part is effective as of such date.

''(b) ENROLLMENT IN A MEDICAREADVANTAGE PLAN.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization shall receive access to such coverage under this part through such plan.

''(2) RULES.—Enrollment in a MedicareAdvantage plan is subject to the rules for enrollment in such plan under section 1851.

''(c) INFORMATION TO ENTITIES TO FACILITATE ENROLLMENT.—Notwithstanding any other provision of law, the Administrator may provide to each eligible entity with a contract under this part such information about eligible beneficiaries as the Administrator determines to be necessary to facilitate efficient enrollment by such beneficiaries with such entities. The Administrator may provide such information only so long as and to the extent necessary to carry out such objective.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D–4. (a) ACTIVITIES.—

''(1) IN GENERAL.—The Administrator shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—The activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860D–3(a)(2).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Administrator under section 1851(d);

''(B) be coordinated with the activities performed by—

''(i) the Administrator under such section; and

''(ii) the Secretary under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan and the formularies and grievance and appeals processes under the plan.

''(B) MONTHLY BENEFICIARY OBLIGATION.—The monthly beneficiary obligation under the plan.

''(C) QUALITY AND PERFORMANCE.—The quality and performance of the eligible entity offering the plan.

''(D) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(E) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan (conducted pursuant to section 1860D–5(h).

''(F) ADDITIONAL INFORMATION.—Such additional information as the Administrator may prescribe.

''BENEFICIARY PROTECTIONS

''SEC. 1860D–5. (a) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan shall disclose, in a clear, accurate, and standardized form to each enrollee at the time of enrollment, and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

''(A) Access to covered drugs, including access through pharmacy networks.

''(B) How any formulary used by the entity functions.

''(C) Copayments, coinsurance, and deductible requirements.

''(D) Grievance and appeals processes.

The information described in the preceding sentence shall also be made available on request to prospective enrollees during open enrollment periods.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll in a Medicare Prescription Drug plan, the eligible entity offering such plan shall provide information similar (as determined by the Administrator) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription Drug plan shall have a mechanism for providing on a timely basis specific information to enrollees upon request, including information on the coverage of specific drugs and changes in its formulary.

''(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan must furnish to enrolled individuals in a form easily understandable to such individuals—

''(A) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

''(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to the initial coverage limit and annual out-of-pocket limit for the current year (except that such notice need not be provided more often than monthly).

''(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(b) ACCESS TO COVERED DRUGS.—

''(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall have in place procedures to ensure that beneficiaries are not charged more than the negotiated price of a covered drug. Such procedures shall include the issuance of a card (or other technology) that may be used by an enrolled beneficiary for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

''(2) ASSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established by the Administrator under section 1860D–7(g) that ensure such convenient access. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(B) USE OF POINT-OF-SERVICE SYSTEM.—An eligible entity offering a Medicare Prescription Drug plan shall establish an optional point-of-service method of operation under which—

''(i) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

''(ii) the plan may charge beneficiaries through adjustments in copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860D–6(c).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity offering a Medicare Prescription Drug plan uses a formulary, the following requirements must be met:

''(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

''(i) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

''(ii) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

''(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate.

''(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

''(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered drugs (as defined by the Administrator), although not necessarily for all drugs within such categories and classes.

''(ii) REQUIREMENT.—In defining therapeutic categories and classes of covered drugs pursuant to clause (i), the Administrator shall use—

''(I) the compendia referred to section 1927(g)(1)(B)(i); and

''(II) other recognized sources of drug classifications and categorizations determined appropriate by the Administrator.

''(D) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(E) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries, physicians, and pharmacists.

''(F) APPEALS AND EXCEPTIONS TO APPLICATION.—The eligible entity must have, as part of the appeals process under subsection (e), a process for timely appeals for denials of coverage based on such application of the formulary.

''(c) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(1) IN GENERAL.—An eligible entity shall have in place the following with respect to covered drugs:

''(A) A cost-effective drug utilization management program, including incentives to reduce costs when appropriate.

''(B) Quality assurance measures to reduce medical errors and adverse drug interactions and to improve medication use, which—

''(i) shall include a medication therapy management program described in paragraph (2); and

''(ii) may include beneficiary education programs, counseling, medication refill reminders, and special packaging.

''(C) A program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure) or multiple prescriptions, that covered drugs under the Medicare Prescription Drug plan are appropriately used to optimize therapeutic outcomes through improved medication use and to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(B) ELEMENTS.—Such program may include—

''(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(iii) detection of patterns of overuse and underuse of prescription drugs.

''(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

''(D) CONSIDERATIONS IN PHARMACY FEES.—The eligible entity offering a Medicare Prescription Drug plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

''(d) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(1) IN GENERAL.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with Medicare Prescription Drug plans of the eligible entity under this part in accordance with section 1852(f).

''(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply to an eligible entity with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

''(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(e) APPEALS.—

''(1) IN GENERAL.—Subject to paragraph (2), the requirements of paragraphs (4) and (5) of section 1852(g) shall apply to an eligible entity with respect to drugs not included on any formulary in a manner that is similar (as determined by the Administrator) to the manner that such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

''(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered drug that is not on a formulary of the entity under the terms applicable for a formulary drug if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(f) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the Medicare Prescription Drug plan offered by the entity, the entity shall have in place procedures to—

''(1) safeguard the privacy of any individually identifiable beneficiary information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996;

''(2) maintain such records and information in a manner that is accurate and timely;

''(3) ensure timely access by such beneficiaries to such records and information; and

''(4) otherwise comply with applicable laws relating to patient privacy and confidentiality.

''(g) UNIFORM MONTHLY PLAN PREMIUM.—An eligible entity shall ensure that the monthly plan premium for a Medicare Prescription Drug plan charged under this part is the same for all eligible beneficiaries enrolled in the plan.

''(h) CONSUMER SATISFACTION SURVEYS.—An eligible entity shall conduct consumer satisfaction surveys with respect to the plan and the entity. The Administrator shall establish uniform requirements for such surveys.

''PRESCRIPTION DRUG BENEFITS

''SEC. 1860D–6. (a) REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of this part and part C, the term 'qualified prescription drug coverage' means either of the following:

''(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (c)) and access to negotiated prices under subsection (e).

''(B) ACTUARIALLY EQUIVALENT PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered drugs which meets the alternative coverage requirements of subsection (d) and access to negotiated prices under subsection (e), but only if it is approved by the Administrator as provided under subsection (d).

''(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–13(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered drugs that exceeds the coverage required under paragraph (1).

''(B) REQUIREMENT.—An eligible entity may not offer a Medicare Prescription Drug plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Drug plan in the area that only provides the coverage of prescription drugs that is required under paragraph (1).

''(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan or the MedicareAdvantage plan may use a variety of cost control mechanisms, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

''(b) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

''(c) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term 'standard prescription drug coverage' means coverage of covered drugs that meets the following requirements:

''(1) DEDUCTIBLE.—

''(A) IN GENERAL.—The coverage has an annual deductible—

''(i) for 2006, that is equal to $275; or

''(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

''(3) INITIAL COVERAGE LIMIT.—

''(A) IN GENERAL.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

''(i) for 2006, that is equal to $4,500; or

''(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

''(A) IN GENERAL.—The coverage provides benefits with cost-sharing that is equal to 20 percent after the individual has incurred costs (as described in subparagraph (C)) for covered drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—

''(i) IN GENERAL.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(I) for 2006, is equal to $3,700; or

''(II) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

''(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(C) APPLICATION.—In applying subparagraph (A)—

''(i) incurred costs shall only include costs incurred, with respect to covered drugs, for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3) (including costs incurred for covered drugs described in section 1860D(a)(2)(C)); and

''(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs, except that only the applicable percent (specified in subparagraph (D)) of the amount of portion of such costs that are paid or reimbursed through insurance, a group health plan, or other third-party payment arrangement for such costs shall not be counted.

''(D) APPLICABLE PERCENT DEFINED.—

''(i) IN GENERAL.—For purposes of subparagraph (C)(ii), but subject to clause (ii), the applicable percent specified in this subparagraph is—

''(I) for years before 2010, 20 percent;

''(II) for 2011, 2012, 2013, 2014, and 2015, 40 percent; and

''(III) for any year thereafter, 100 percent.

''(ii) SECRETARIAL LIMITATION ON TOTAL EXPENDITURES.—The Secretary, in consultation with the Office of Management and Budget, shall estimate at the time of enactment of this part, the aggregate budget outlays that will result during the 10-fiscal-year period beginning with fiscal year 2004 from the enactment of the Prescription Drug and Medicare Improvement Act of 2003. If such estimate exceeds $393,000,000,000, the Secretary shall provide for such proportional reductions in the percentages specified in clause (i) as the Secretary determines to be necessary to assure that such aggregate budget outlays during such period do not exceed such amount.

''(E) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the entities in which such individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may also periodically ask individuals enrolled in a plan offered by the entity whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D–2(d).

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered drugs in the United States for beneficiaries under this title, as determined by the Administrator for the 12-month period ending in July of the previous year.

''(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan or MedicareAdvantage plan may provide a different prescription drug benefit design from the standard prescription drug coverage described in subsection (c) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan

applies for, and receives, the approval of the Administrator for such benefit design:

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT PRESCRIPTION DRUG COVERAGE.—

''(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (f)) is at least equal to the actuarial value (as so determined) of standard prescription drug coverage.

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1860D–17(c) and reinsurance payments under section 1860D–20 with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (f)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (c)(3), of an amount equal to at least the product of—

''(i) such initial coverage limit minus the deductible under subsection (c)(1); and

''(ii) the percentage specified in subsection (c)(2).

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

''(2) DEDUCTIBLE AND LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES MAY NOT VARY.—The coverage may not vary the deductible under subsection (c)(1) for the year or the limitation on out-of-pocket expenditures by beneficiaries described in subsection (c)(4) for the year.

''(e) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—

''(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a MedicareAdvantage organization, the entity or organization shall provide beneficiaries with access to negotiated prices used for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the deductible, any cost-sharing, or an initial coverage limit (described in subsection (c)(3)). For purposes of this part, the term 'negotiated prices' includes all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations and shall reflect prices that are no higher than the prices negotiated by the Secretary under subparagraph (B).

''(B) SECRETARIAL NEGOTIATED PRICE.—Notwithstanding any other provision of this part, the Secretary shall, consistent with the requirements of this part and the goals of providing quality care and containing costs under this part, negotiate contracts with manufacturers of covered outpatient prescription drugs that provide for the maximum prices that may be charged to individuals enrolled under this part by participating pharmacies for dispensing such drugs to such individuals.

''(C) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a MedicareAdvantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(2) CARDS OR OTHER TECHNOLOGY.—

''(A) IN GENERAL.—In providing the access under paragraph (1), the eligible entity or MedicareAdvantage organization shall issue a card or use other technology pursuant to section 1860D–5(b)(1).

''(B) NATIONAL STANDARDS.—

''(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with parts C and D of title XI and may be based on standards developed by an appropriate standard setting organization.

''(ii) CONSULTATION.—In developing the standards under clause (i), the Administrator shall consult with the National Council for Prescription Drug Programs and other standard-setting organizations determined appropriate by the Administrator.

''(iii) IMPLEMENTATION.—The Administrator shall implement the standards developed under clause (i) by January 1, 2008.

''(3) DISCLOSURE.—The eligible entity offering a Medicare Prescription Drug plan and the MedicareAdvantage organization offering a MedicareAdvantage plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made available to the entity or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

''(4) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D–7(f)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a MedicareAdvantage organization offering a MedicareAdvantage plan.

''(f) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

''(1) PROCESSES.—For purposes of this section, the Administrator shall establish processes and methods—

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard prescription drug coverage and of the reinsurance payments under section 1860D–20;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (d) as is used with respect to determinations of standard prescription drug coverage under subsection (c); and

''(B) for determining annual percentage increases described in subsection (c)(5).

Such processes shall take into account any effect that providing actuarially equivalent prescription drug coverage rather than standard prescription drug coverage has on drug utilization.

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and MedicareAdvantage organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

''REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

''SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Drug plan shall meet the following requirements:

''(1) LICENSURE.—Subject to subsection (c), the entity is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare Prescription Drug plan.

''(2) ASSUMPTION OF FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and subsections (d)(2) and (e) of section 1860D–13, to the extent that the entity is at risk pursuant to such section 1860D–16, the entity assumes financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Drug plan and that is not covered under section 1860D–20.

''(B) REINSURANCE PERMITTED.—To the extent that the entity is at risk pursuant to section 1860D–16, the entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the case of an eligible entity that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such entity shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—The Administrator shall not permit an eligible beneficiary to elect a Medicare Prescription Drug plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 1860D–16 or 1860D–20, unless the Administrator has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Drug plan. Such contract shall provide that the entity agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER TO ENSURE BENEFICIARY CHOICE.—

''(1) IN GENERAL.—In the case of an eligible entity that seeks to offer a Medicare Prescription Drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) have been met.

''(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

''(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

''(4) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this

subsection to Medicare Prescription Drug plans and eligible entities—

''(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

''(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (d).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

''(1) ESTABLISHMENT AND PUBLICATION.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

''(2) COMPLIANCE WITH STANDARDS.—An eligible entity that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such eligible entities with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the eligible entity to meet other requirements imposed under this part for an eligible entity.

''(f) INCORPORATION OF CERTAIN MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(4), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

''(1) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

''(2) INTERMEDIATE SANCTIONS.—Section 1857(g), except that in applying such section—

''(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

''(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

''(3) PROCEDURES FOR TERMINATION.—Section 1857(h).

''(g) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Drug plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by January 1, 2005.

''(h) PERIODIC REVIEW AND REVISION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards if the Administrator determines such revision to be appropriate.

''(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Administrator may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on an eligible entity or a Medicare Prescription Drug plan.

''(i) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Drug plans which are offered by eligible entities under this part—

''(A) to the extent such law or regulation is inconsistent with such standards; and

''(B) in the same manner as such laws and regulations are superseded under section 1856(b)(3).

''(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this section:

''(A) Benefit requirements, including requirements relating to cost-sharing and the structure of formularies.

''(B) Premiums.

''(C) Requirements relating to inclusion or treatment of providers.

''(D) Coverage determinations (including related appeals and grievance processes).

''(E) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare Prescription Drug plan.

''(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to—

''(A) monthly beneficiary obligations paid to the Administrator for Medicare Prescription Drug plans under this part; or

''(B) any payments made by the Administrator under this part to an eligible entity offering such a plan.

''Subpart 2—Prescription Drug Delivery System

''ESTABLISHMENT OF SERVICE AREAS

''SEC. 1860D–10. (a) ESTABLISHMENT.—

''(1) INITIAL ESTABLISHMENT.—Not later than April 15, 2005, the Administrator shall establish and publish the service areas in which Medicare Prescription Drug plans may offer benefits under this part.

''(2) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Administrator shall periodically review the service areas applicable under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

''(b) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE AREAS.—

''(1) IN GENERAL.—The Administrator shall establish the service areas under subsection (a) in a manner that—

''(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

''(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

''(2) ADDITIONAL REQUIREMENTS.—The Administrator shall establish the service areas under subsection (a) consistent with the following requirements:

''(A) There shall be at least 10 service areas.

''(B) Each service area must include at least 1 State.

''(C) The Administrator may not divide States so that portions of the State are in different service areas.

''(D) To the extent possible, the Administrator shall include multistate metropolitan statistical areas in a single service area. The Administrator may divide metropolitan statistical areas where it is necessary to establish service areas of such size and geography as to maximize the participation of Medicare Prescription Drug plans.

''(3) MAY CONFORM TO MEDICAREADVANTAGE PREFERRED PROVIDER REGIONS.—The Administrator may conform the service areas established under this section to the preferred provider regions established under section 1858(a)(3).

''PUBLICATION OF RISK ADJUSTERS

''SEC. 1860D–11. (a) PUBLICATION.—Not later than April 15 of each year (beginning in 2005), the Administrator shall publish the risk adjusters established under subsection (b) to be used in computing—

''(1) the amount of payment to Medicare Prescription Drug plans in the subsequent year under section 1860D–16(a), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage); and

''(2) the amount of payment to MedicareAdvantage plans in the subsequent year under section 1858A(c), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

''(b) ESTABLISHMENT OF RISK ADJUSTERS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to plans referred to in subsection (a) to take into account variation in costs based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments described in paragraphs (1) and (2) of subsection (a).

''(2) CONSIDERATIONS.—In establishing the methodology under paragraph (1), the Administrator may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MedicareAdvantage organizations.

''(3) DATA COLLECTION.—In order to carry out this subsection, the Administrator shall require—

''(A) eligible entities to submit data regarding drug claims that can be linked at the beneficiary level to part A and part B data and such other information as the Administrator determines necessary; and

''(B) MedicareAdvantage organizations (except MSA plans or a private fee-for-service plan that does not provide qualified prescription drug coverage) to submit data regarding drug claims that can be linked to other data that such organizations are required to submit to the Administrator and such other information as the Administrator determines necessary.

''SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–12. (a) SUBMISSION.—

''(1) IN GENERAL.—Each eligible entity that intends to offer a Medicare Prescription Drug plan in an area in a year (beginning with 2006) shall submit to the Administrator, at such time in the previous year and in such manner as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b).

''(2) ANNUAL SUBMISSION.—An eligible entity shall submit the information required under paragraph (1) with respect to a Medicare Prescription Drug plan that the entity intends to offer on an annual basis.

''(b) INFORMATION DESCRIBED.—The information described in this subsection includes information on each of the following:

''(1) The benefits under the plan (as required under section 1860D–6).

''(2) The actuarial value of the qualified prescription drug coverage.

''(3) The amount of the monthly plan premium under the plan, including an actuarial certification of—

''(A) the actuarial basis for such monthly plan premium;

''(B) the portion of such monthly plan premium attributable to standard prescription drug coverage or actuarially equivalent prescription drug coverage and, if applicable, to benefits that are in addition to such coverage; and

''(C) the reduction in such monthly plan premium resulting from the payments provided under section 1860D–20.

''(4) The service area for the plan.

''(5) Whether the entity plans to use any funds in the plan stabilization reserve fund in the Prescription Drug Account that are

available to the entity to stabilize or reduce the monthly plan premium submitted under paragraph (3), and if so, the amount in such reserve fund that is to be used.

''(6) Such other information as the Administrator may require to carry out this part.

''(c) OPTIONS REGARDING SERVICE AREAS.—

''(1) IN GENERAL.—The service area of a Medicare Prescription Drug plan shall be either—

''(A) the entire area of 1 of the service areas established by the Administrator under section 1860D–10; or

''(B) the entire area covered by the medicare program.

''(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as prohibiting an eligible entity from submitting separate bids in multiple service areas as long as each bid is for a single service area.

''APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–13. (a) APPROVAL.—

''(1) IN GENERAL.—The Administrator shall review the information filed under section 1860D–12 and shall approve or disapprove the Medicare Prescription Drug plan.

''(2) REQUIREMENTS FOR APPROVAL.—The Administrator may not approve a Medicare Prescription Drug plan unless the following requirements are met:

''(A) COMPLIANCE WITH REQUIREMENTS.—The plan and the entity offering the plan comply with the requirements under this part.

''(B) APPLICATION OF FEHBP STANDARD.—(i) The portion of the monthly plan premium submitted under section 1860D–12(b) that is attributable to standard prescription drug coverage reasonably and equitably reflects the actuarial value of the standard prescription drug coverage less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

''(ii) If the plan provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium reasonably and equitably reflects the actuarial value of the coverage provided less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

''(b) NEGOTIATION.—In exercising the authority under subsection (a), the Administrator shall have the authority to—

''(1) negotiate the terms and conditions of the proposed monthly plan premiums submitted and other terms and conditions of a proposed plan; and

''(2) disapprove, or limit enrollment in, a proposed plan based on—

''(A) the costs to beneficiaries under the plan;

''(B) the quality of the coverage and benefits under the plan;

''(C) the adequacy of the network under the plan; or

''(D) other factors determined appropriate by the Administrator.

''(c) SPECIAL RULES FOR APPROVAL.—The Administrator may approve a Medicare Prescription Drug plan submitted under section 1860D–12 only if the benefits under such plan—

''(1) include the required benefits under section 1860D–6(a)(1); and

''(2) are not designed in such a manner that the Administrator finds is likely to result in favorable selection of eligible beneficiaries.

''(d) ACCESS TO COMPETITIVE COVERAGE.—

''(1) NUMBER OF CONTRACTS.—The Administrator, consistent with the requirements of this part and the goal of containing costs under this title, shall, with respect to a year, approve at least 2 contracts to offer a Medicare Prescription Drug plan in each service area (established under section 1860D–10) for the year.

''(2) AUTHORITY TO REDUCE RISK TO ENSURE ACCESS.—

''(A) IN GENERAL.—Subject to subparagraph (B), if the Administrator determines, with respect to an area, that the access required under paragraph (1) is not going to be provided in the area during the subsequent year, the Administrator shall—

''(i) adjust the percents specified in paragraphs (2) and (4) of section 1860D–16(b) in an area in a year; or

''(ii) increase the percent specified in section 1860D–20(c)(1) in an area in a year.

The administrator shall exercise the authority under the preceding sentence only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(B) REQUIREMENTS FOR USE OF AUTHORITY.—In exercising authority under subparagraph (A), the Administrator—

''(i) shall not provide for the full underwriting of financial risk for any eligible entity;

''(ii) shall not provide for any underwriting of financial risk for a public eligible entity with respect to the offering of a nationwide Medicare Prescription Drug plan; and

''(iii) shall seek to maximize the assumption of financial risk by eligible entities to ensure fair competition among Medicare Prescription Drug plans.

''(C) REQUIREMENT TO ACCEPT 2 FULL-RISK QUALIFIED BIDS BEFORE EXERCISING AUTHORITY.—The Administrator may not exercise the authority under subparagraph (A) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year under paragraph (1) before the application of subparagraph (A).

''(D) REPORTS.—The Administrator, in each annual report to Congress under section 1808(c)(1)(D), shall include information on the exercise of authority under subparagraph (A). The Administrator also shall include such recommendations as may be appropriate to limit the exercise of such authority.

''(e) GUARANTEED ACCESS.—

''(1) ACCESS.—In order to assure access to qualified prescription drug coverage in an area, the Administrator shall take the following steps:

''(A) DETERMINATION.—Not later than September 1 of each year (beginning in 2005) and for each area (established under section 1860D–10), the Administrator shall make a determination as to whether the access required under subsection (d)(1) is going to be provided in the area during the subsequent year. Such determination shall be made after the Administrator has exercised the authority under subsection (d)(2).

''(B) CONTRACT WITH AN ENTITY TO PROVIDE COVERAGE IN AN AREA.—Subject to paragraph (3), if the Administrator makes a determination under subparagraph (A) that the access required under subsection (d)(1) is not going to be provided in an area during the subsequent year, the Administrator shall enter into a contract with an entity to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage enrolled in a MedicareAdvantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) during the subsequent year. An entity may be awarded a contract for more than 1 of the areas for which the Administrator is required to enter into a contract under this paragraph but the Administrator may enter into only 1 such contract in each such area. An entity with a contract under this part shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(C) REQUIREMENT TO ACCEPT 2 REDUCED-RISK QUALIFIED BIDS BEFORE ENTERING INTO CONTRACT.—The Administrator may not enter into a contract under subparagraph (B) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year after the Administrator has exercised the authority under subsection (d)(2) in the area for the year.

''(D) ENTITY REQUIRED TO MEET BENEFICIARY PROTECTION AND OTHER REQUIREMENTS.—An entity with a contract under subparagraph (B) shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(E) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under subparagraph (B).

''(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

''(A) IN GENERAL.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(B), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D–17(c)) of the monthly national average premium (as computed under section 1860D–15) for the area for the year, as adjusted using the geographic adjuster under subparagraph (B).

''(B) ESTABLISHMENT OF GEOGRAPHIC ADJUSTER.—The Administrator shall establish an appropriate methodology for adjusting the monthly beneficiary obligation (as computed under subparagraph (A)) for the year in an area to take into account differences in drug prices among areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in an area and eligible beneficiaries in other areas and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Administrator had not applied such adjustment.

''(3) PAYMENTS UNDER THE CONTRACT.—

''(A) IN GENERAL.—A contract entered into under paragraph (1)(B) shall provide for—

''(i) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

''(ii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

''(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

''(i) The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and with the entity.

''(ii) The entity provides such beneficiaries with quality clinical care.

''(iii) The entity provides such beneficiaries with quality services.

''(C) ENTITY ONLY AT RISK TO THE EXTENT OF THE FEES TIED TO PERFORMANCE REQUIREMENTS.—An entity with a contract under paragraph (1)(B) shall only be at risk for the provision of benefits under the contract to the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

''(4) ELIGIBLE ENTITY THAT SUBMITTED A BID FOR THE AREA NOT ELIGIBLE TO BE AWARDED THE CONTRACT.—An eligible entity that submitted a bid to offer a Medicare Prescription Drug plan for an area for a year under section 1860D–12, including a bid submitted after the Administrator has exercised the authority under subsection (d)(2), may not be awarded a contract under paragraph (1)(B) for that area and year. The previous sentence shall apply to an entity that was awarded a contract under paragraph (1)(B) for the area in the previous year and submitted such a bid under section 1860D–12 for the year.

''(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

''(A) The contract shall be for a 2-year period.

''(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

''(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D-6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

''(6) ENTITY NOT PERMITTED TO MARKET OR BRAND THE CONTRACT.—An entity with a contract under paragraph (1)(B) may not engage in any marketing or branding of such contract.

''(7) RULES FOR AREAS WHERE ONLY 1 COMPETITIVELY BID PLAN WAS APPROVED.—In the case of an area where (before the application of this subsection) only 1 Medicare Prescription Drug plan was approved for a year—

''(A) the plan may (at the option of the plan) be offered in the area for the year (under rules applicable to such plans under this part and not under this subsection);

''(B) eligible beneficiaries described in paragraph (1)(B) may receive access to qualified prescription drug coverage through enrollment in the plan or with an entity with a contract under paragraph (1)(B); and

''(C) for purposes of applying section 1860D–3(a)(1)(A)(ii), such plan shall be the plan designated in the area under such section.

''(f) TWO-YEAR CONTRACTS.—Except for a contract entered into under subsection (e)(1)(B), a contract approved under this part (including a contract under) shall be for a 2-year period.

''COMPUTATION OF MONTHLY STANDARD PRESCRIPTION DRUG COVERAGE PREMIUMS

''SEC. 1860D–14. (a) IN GENERAL.—For each year (beginning with 2006), the Administrator shall compute a monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13 and for each MedicareAdvantage plan.

''(b) REQUIREMENTS.—The monthly standard prescription drug coverage premium for a plan for a year shall be equal to—

''(1) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides standard prescription drug coverage or an actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium approved for the plan under section 1860D–13 for the year; and

''(2) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2)—

''(A) an amount that reflects only the actuarial value of the standard prescription drug coverage offered under the plan; or

''(B) if determined appropriate by the Administrator, the monthly plan premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan (or, if applicable, the MedicareAdvantage plan) that, as required under section 1860D–6(a)(2)(B) for a Medicare Prescription Drug plans and a MedicareAdvantage plan—

''(i) is offered by such entity or organization in the same area as the plan; and

''(ii) does not provide additional prescription drug coverage pursuant to such section.

''COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

''SEC. 1860D–15. (a) COMPUTATION.—

''(1) IN GENERAL.—For each year (beginning with 2006) the Administrator shall compute a monthly national average premium equal to the average of the monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan and each MedicareAdvantage plan (as computed under section 1860D–14). Such premium may be adjusted pursuant to any methodology determined under subsection (b), as determined appropriate by the Administrator.

''(2) WEIGHTED AVERAGE.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

''(b) GEOGRAPHIC ADJUSTMENT.—The Administrator shall establish an appropriate methodology for adjusting the monthly national average premium (as computed under subsection (a)) for the year in an area to take into account differences in prices for covered drugs among different areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in that area and other eligible beneficiaries and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner as to not result in a change in aggregate payments made under this part than would have been made if the Administrator had not applied such adjustment.

''(c) SPECIAL RULE FOR 2006.—For purposes of applying this section for 2006, the Administrator shall establish procedures for determining the weighted average under subsection (a)(2) for 2005.

''PAYMENTS TO ELIGIBLE ENTITIES

''SEC. 1860D–16. (a) PAYMENT OF MONTHLY PLAN PREMIUMS.—For each year (beginning with 2006), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly plan premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(b) PORTION OF TOTAL PAYMENTS OF MONTHLY PLAN PREMIUMS SUBJECT TO RISK.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For each year (beginning in 2007), the eligible entity offering a Medicare Prescription Drug plan shall notify the Administrator of the following:

''(i) TOTAL ACTUAL COSTS.—The total amount of costs that the entity incurred in providing standard prescription drug coverage (or prescription drug coverage that is actuarially equivalent pursuant to section 1860D–6(a)(1)(B)) for all enrollees under the plan in the previous year.

''(ii) ACTUAL COSTS FOR SPECIFIC DRUGS.—With respect to the total amount under clause (i) for the year, a breakdown of—

''(I) each covered drug that constitutes a portion of such amount;

''(II) the negotiated price for the eligible entity for each such drug;

''(III) the number of prescriptions; and

''(IV) the average beneficiary coinsurance rate for a each covered drug that constitutes a portion of such amount.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The amounts under clauses (i) and (ii)(II) of subparagraph (A) may not include—

''(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

''(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2); or

''(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN RISK CORRIDOR.—If the allowable costs (specified in paragraph (3)) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (4)(A)(i)) for the plan for the year, then no additional payments shall be made by the Administrator and no payments shall be made by (or collected from) the eligible entity offering the plan.

''(B) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

''(i) IN GENERAL.—If the allowable costs for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Administrator shall increase the total of the monthly payments made to the entity offering the plan for the year under subsection (a) by an amount equal to the sum of—

''(I) the applicable percent (as defined in subparagraph (D)) of such allowable costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(iv)); and

''(II) 90 percent of such allowable costs which are more than such second threshold upper limit of the risk corridor.

''(ii) SPECIAL TRANSITIONAL CORRIDOR FOR 2006 AND 2007.—If the Administrator determines with respect to 2006 or 2007 that at least 60 percent of Medicare Prescription Drug plans and MedicareAdvantage Plans (excluding MSA plans or private fee-for-service plans that do not provide qualified prescription drug coverage) have allowable costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year and that such plans represent at least 60 percent of eligible beneficiaries enrolled under this part, clause (i)(I) shall be applied by substituting '90 percent' for 'applicable percent'.

''(C) PLAN PAYMENT IF ALLOWABLE COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the allowable costs for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the entity offering the plan shall a make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to—

''(i) the applicable percent (as so defined) of such allowable costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(ii)); and

''(ii) 90 percent of such allowable costs which are less than such second threshold lower limit of the risk corridor.

''(D) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term 'applicable percent' means—

''(i) for 2006 and 2007, 75 percent; and

''(ii) for 2008 and subsequent years, 50 percent.

''(3) ESTABLISHMENT OF ALLOWABLE COSTS.—

''(A) IN GENERAL.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year, adjusted under subparagraph (B)(ii).

''(B) REPRICING OF COSTS.—

''(i) CALCULATION OF AVERAGE PLAN COST.—Utilizing the information obtained under paragraph (1)(A)(ii) and section 1860D–20(b)(1)(B), for each year (beginning with 2006), the Administrator shall establish an average negotiated price with respect to all Medicare Prescription Drug plans for each covered drug.

''(ii) ADJUSTMENT IF ACTUAL COSTS EXCEED AVERAGE COSTS.—With respect to a Medicare Prescription Drug plan for a year, the Administrator shall reduce the amount described in paragraph (1)(A)(i) for the plan for the year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under paragraph (1)(A)(ii)) for which the negotiated prices are greater than the average negotiated price for the covered drug for the year (as determined under clause (i)).

''(4) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For each year (beginning with 2006), the Administrator shall establish a risk corridor for each Medicare Prescription Drug plan. The risk corridor for a plan for a year shall be equal to a range as follows:

''(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

''(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

''(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

''(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a Medicare Prescription Drug plan offered by an eligible entity in a year—

''(i) in the case of a plan offered by an eligible entity that provides standard prescription drug coverage or actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a), reduced by the percentage specified in subparagraph (D); and

''(ii) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a) that are related to standard prescription drug coverage (determined using the rules under section 1860D–14(b)), reduced by the percentage specified in subparagraph (D).

''(C) FIRST AND SECOND THRESHOLD RISK PERCENTAGE DEFINED.—

''(i) FIRST THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

''(I) for 2006 and 2007, and 2.5 percent;

''(II) for 2008 through 2011, 5 percent; and

''(III) for 2012 and subsequent years, a percentage established by the Administrator, but in no case less than 5 percent.

''(ii) SECOND THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

''(I) for 2006 and 2007, 5.0 percent;

''(II) for 2008 through 2011, 10 percent

''(III) for 2012 and subsequent years, a percentage established by the Administrator that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

''(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to paragraph (2) of section 1860D–13(d), the Administrator may reduce the applicable first or second threshold risk percentage in an area in a year in order to ensure the access to plans required under paragraph (1) of such section.

''(D) TARGET AMOUNT NOT TO INCLUDE ADMINISTRATIVE EXPENSES NEGOTIATED BETWEEN THE ADMINISTRATOR AND THE ENTITY OFFERING THE PLAN.—For each year (beginning in 2006), the Administrator and the entity offering a Medicare Prescription Drug plan shall negotiate, as part of the negotiation process described in section 1860D–13(b) during the previous year, the percentage of the payments to the entity under subsection (a) with respect to the plan that are attributable and reasonably incurred for administrative expenses for providing standard prescription drug coverage or actuarially equivalent prescription drug coverage in the year.

''(5) PLANS AT RISK FOR ENTIRE AMOUNT OF ADDITIONAL PRESCRIPTION DRUG COVERAGE.—An eligible entity that offers a Medicare Prescription Drug plan that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2) shall be at full financial risk for the provision of such additional coverage.

''(6) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

''(7) DISCLOSURE OF INFORMATION.—

''(A) IN GENERAL.—Each contract under this part shall provide that—

''(i) the entity offering a Medicare Prescription Drug plan shall provide the Administrator with such information as the Administrator determines is necessary to carry out this section; and

''(ii) the Administrator shall have the right to inspect and audit any books and records of the eligible entity that pertain to the information regarding costs provided to the Administrator under paragraph (1).

''(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

''(c) STABILIZATION RESERVE FUND.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—There is established, within the Prescription Drug Account, a stabilization reserve fund in which the Administrator shall deposit amounts on behalf of eligible entities in accordance with paragraph (2) and such amounts shall be made available by the Secretary for the use of eligible entities in contract year 2008 and subsequent contract years in accordance with paragraph (3).

''(B) REVERSION OF UNUSED AMOUNTS.—Any amount in the stabilization reserve fund established under subparagraph (A) that is not expended by an eligible entity in accordance with paragraph (3) or that was deposited for the use of an eligible entity that no longer has a contract under this part shall revert for the use of the Prescription Drug Account.

''(2) DEPOSIT OF AMOUNTS FOR 5 YEARS.—

''(A) IN GENERAL.—If the target amount for a Medicare Prescription Drug plan for 2006, 2007, 2008, 2009, or 2010 (as determined under subsection (b)(4)(B)) exceeds the applicable costs for the plan for the year by more than 3 percent, then—

''(i) the entity offering the plan shall make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to the portion of such excess that is in excess of 3 percent of the target amount; and

''(ii) the Administrator shall deposit an amount equal to the amount collected or otherwise recovered under clause (i) in the stabilization reserve fund on behalf of the eligible entity offering such plan.

''(B) APPLICABLE COSTS.—For purposes of subparagraph (A), the term 'applicable costs' means, with respect to a Medicare Prescription Drug plan and year, an amount equal the sum of—

''(i) the allowable costs for the plan and year (as determined under subsection (b)(3)(A); and

''(ii) the total amount by which monthly payments to the plan were reduced (or otherwise recovered from the plan) for the year under subsection (b)(2)(C).

''(3) USE OF RESERVE FUND TO STABILIZE OR REDUCE MONTHLY PLAN PREMIUMS.—

''(A) IN GENERAL.—For any contract year beginning after 2007, an eligible entity offering a Medicare Prescription Drug plan may use funds in the stabilization reserve fund in the Prescription Drug Account that were deposited in such fund on behalf of the entity to stabilize or reduce monthly plan premiums submitted under section 1860D–12(b)(3).

''(B) PROCEDURES.—The Administrator shall establish procedures for—

''(i) reducing monthly plan premiums submitted under section 1860D–12(b)(3) pursuant to subparagraph (A); and

''(ii) making payments from the plan stabilization reserve fund in the Prescription Drug Account to eligible entities that inform the Secretary under section 1860D–12(b)(5) of the entity's intent to use funds in such reserve fund to reduce such premiums.

''(d) PORTION OF PAYMENTS OF MONTHLY PLAN PREMIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES TIED TO PERFORMANCE REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator shall establish procedures to adjust the portion of the payments made to an entity under subsection (a) that are attributable to administrative expenses (as determined pursuant to subsection (b)(4)(D)) to ensure that the entity meets the performance requirements described in clauses (ii) and (iii) of section 1860D–13(e)(4)(B).

''(2) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

''(e) PAYMENT TERMS.—

''(1) ADMINISTRATOR PAYMENTS.—Payments to an entity offering a Medicare Prescription Drug plan under this section shall be made in a manner determined by the Administrator and based upon the manner in which payments are made under section 1853(a) (relating to payments to MedicareAdvantage organizations).

''(2) PLAN PAYMENTS.—The Administrator shall establish a process for collecting (or other otherwise recovering) amounts that an entity offering a Medicare Prescription Drug plan is required to make to the Administrator under this section.

''(f) PAYMENTS TO MEDICAREADVANTAGE PLANS.—For provisions related to payments to MedicareAdvantage organizations offering MedicareAdvantage plans for qualified prescription drug coverage made available under the plan, see section 1858A(c).

''(g) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION

''SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan in a year shall be determined as follows:

''(1) MONTHLY PLAN PREMIUM EQUALS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the applicable percent (as determined in subsection (c)) of the amount of such monthly national average premium.

''(2) MONTHLY PLAN PREMIUM LESS THAN MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for the Medicare Prescription Drug plan for the year is less than the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to—

''(A) the applicable percent of the amount of such monthly national average premium; minus

''(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

''(3) MONTHLY PLAN PREMIUM EXCEEDS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the sum of—

''(A) the applicable percent of the amount of such monthly national average premium; plus

''(B) the amount by which the monthly plan premium approved by the Administrator for the plan exceeds the amount of such monthly national average premium.

''(b) BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—In the case of an eligible beneficiary that is enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), the Medicare monthly beneficiary obligation for qualified prescription drug coverage shall be determined pursuant to section 1858A(d).

''(c) APPLICABLE PERCENT.—For purposes of this section, except as provided in section 1860D–19 (relating to premium subsidies for low-income individuals), the applicable percent for any year is the percentage equal to a fraction—

''(1) the numerator of which is 27.5 percent; and

''(2) the denominator of which is 100 percent minus a percentage equal to—

''(A) the total reinsurance payments which the Administrator estimates will be made under section 1860D–20 to qualifying entities described in subsection (e)(3) of such section during the year; divided by

''(B) the sum of—

''(i) the amount estimated under subparagraph (A) for the year; and

''(ii) the total payments which the Administrator estimates will be made under sections 1860D–16 and 1858A(c) during the year that relate to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

''COLLECTION OF MONTHLY BENEFICIARY OBLIGATION

''SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the monthly beneficiary obligation (determined under section 1860D–17) applicable to an eligible beneficiary under this part (after application of any increase under section 1860D–2(b)(1)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(2) PROCEDURES FOR SPONSOR TO PAY OBLIGATION ON BEHALF OF RETIREE.—The Administrator shall establish procedures under which an eligible beneficiary enrolled in a Medicare Prescription Drug plan may elect to have the sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section) in which the beneficiary is enrolled pay the amount of the monthly beneficiary obligation applicable to the beneficiary under this part directly to the Administrator.

''(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

''(1) by the beginning of each year, the name, social security account number, monthly beneficiary obligation owed by each individual enrolled in a Medicare Prescription Drug plan for each month during the year, and other information determined appropriate by the Administrator; and

''(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

''(c) COLLECTION FOR BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—For provisions related to the collection of the monthly beneficiary obligation for qualified prescription drug coverage under a MedicareAdvantage plan, see section 1858A(e).

''PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860D–19. (a) AMOUNT OF SUBSIDIES.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.—In the case of a qualified medicare beneficiary (as defined in paragraph (4)(A))—

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

''(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

''(C) section 1860D–6(c)(2) shall be applied by substituting '2.5 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 5.0 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

''(2) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SPECIFIED LOW INCOME MEDICARE BENEFICIARIES AND QUALIFYING INDIVIDUALS.—In the case of a specified low income medicare beneficiary (as defined in paragraph (4)(B)) or a qualifying individual (as defined in paragraph (4)(C))—

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

''(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a

monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

''(C) section 1860D–6(c)(2) shall be applied by substituting '5.0 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 10.0 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

''(3) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—

''(A) IN GENERAL.—In the case of a subsidy-eligible individual (as defined in paragraph (4)(D))—

''(i) section 1860D–17 shall be applied—

''(I) in subsection (c), by substituting 'subsidy percent' for the applicable percentage that would otherwise apply under such subsection; and

''(II) in subparagraphs (A) and (B) of subsection (a)(3), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year; and

''(ii) the annual deductible applicable under section 1860D–6(c)(1)—

''(I) for 2006, shall be reduced to $50; and

''(II) for a subsequent year, shall be reduced to the amount specified under this clause for the previous year increased by the percentage specified in section 1860D–6(c)(5) for the year involved;

''(iii) section 1860D–6(c)(2) shall be applied by substituting '10.0 percent' for '50 percent' each place it appears;

''(iv) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 20.0 percent; and

''(v) such individual shall be responsible for the cost-sharing described in section 1860D–6(c)(4)(A).

In no case may the application of clause (i) result in a monthly beneficiary obligation that is below 0.

''(B) SUBSIDY PERCENT DEFINED.—For purposes of subparagraph (A)(i), the term 'subsidy percent' means, with respect to a State, a percent determined on a linear sliding scale ranging from—

''(i) 0 percent with respect to a subsidy-eligible individual residing in the State whose income does not exceed 135 percent of the poverty line; to

''(ii) the highest percentage that would otherwise apply under section 1860D–17 in the service area in which the subsidy-eligible individual resides, in the case of a subsidy-eligible individual residing in the State whose income equals 160 percent of the poverty line.

''(4) DEFINITIONS.—In this part:

''(A) QUALIFIED MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'qualified medicare beneficiary' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) is described in section 1905(p)(1).

''(B) SPECIFIED LOW INCOME MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'specified low income medicare beneficiary' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) is described in section 1902(a)(10)(E)(iii).

''(C) QUALIFYING INDIVIDUAL.—Subject to subparagraph (H), the term 'qualifying individual' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) is described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX).

''(D) SUBSIDY-ELIGIBLE INDIVIDUAL.—Subject to subparagraph (H), the term 'subsidy-eligible individual' means an individual—

''(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) whose income is less than 160 percent of the poverty line; and

''(iii) who is not—

''(I) a qualified medicare beneficiary;

''(II) a specified low-income medicare beneficiary; or

''(III) a qualifying individual. *

''(E) POVERTY LINE.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(F) ELIGIBILITY DETERMINATIONS.—Beginning on November 1, 2005, the determination of whether an individual residing in a State is an individual described in subparagraph (A), (B), (C), or (D) and, for purposes of paragraph (3), the amount of an individual's income, shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

''(G) NONAPPLICATION TO TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia—

''(i) the subsidies provided under this section shall not apply; and

''(ii) such individuals may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with section 1935 under the State medicaid program under title XIX.

''(b) RULES IN APPLYING COST-SHARING SUBSIDIES.—Nothing in this section shall be construed as preventing an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan from waiving or reducing the amount of the deductible or other cost-sharing otherwise applicable pursuant to section 1860D–6(a)(2).

''(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall establish a process whereby, in the case of an individual eligible for a cost-sharing subsidy under subsection (a) who is enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan—

''(1) the Administrator provides for a notification of the eligible entity or MedicareAdvantage organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

''(2) the entity or organization involved reduces the cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

''(3) the Administrator periodically and on a timely basis reimburses the entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

''(d) RELATION TO MEDICAID PROGRAM.—For provisions providing for eligibility determinations and additional Federal payments for expenditures related to providing prescription drug coverage for territorial residents under the medicaid program, see section 1935.

''REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD

''SEC. 1860D–20. (a) REINSURANCE PAYMENTS.—

''(1) IN GENERAL.—Subject to section 1860D–21(b), the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

''(2) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

''(b) NOTIFICATION OF SPENDING UNDER THE PLAN FOR COSTS INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD.—

''(1) IN GENERAL.—Each qualifying entity shall notify the Administrator of the following with respect to a qualifying covered individual for a coverage year:

''(A) TOTAL ACTUAL COSTS.—The total amount (if any) of costs that the qualifying entity incurred in providing prescription drug coverage for the individual in the year after the individual had reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

''(B) ACTUAL COSTS FOR SPECIFIC DRUGS.—With respect to the total amount under subparagraph (A) for the year, a breakdown of—

''(i) each covered drug that constitutes a portion of such amount;

''(ii) the negotiated price for the qualifying entity for each such drug;

''(iii) the number of prescriptions; and

''(iv) the average beneficiary coinsurance rate for a each covered drug that constitutes a portion of such amount.

''(2) CERTAIN EXPENSES NOT INCLUDED.—The amounts under subparagraphs (A) and (B)(ii) of paragraph (1) may not include—

''(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A); or

''(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2).

''(3) RESTRICTION ON USE OF INFORMATION.—The restriction specified in section 1860D–16(b)(7)(B) shall apply to information disclosed or obtained pursuant to the provisions of this section.

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—The reinsurance payment amount under this subsection for a qualifying covered individual for a coverage year is an amount equal to 80 percent of the allowable costs (as specified in paragraph (2)) incurred by the qualifying entity with respect to the individual and year.

''(2) ALLOWABLE COSTS.—*

''(A) IN GENERAL.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year, adjusted under subparagraph (B).

''(B) REPRICING OF COSTS IF ACTUAL COSTS EXCEED AVERAGE COSTS.—The Administrator shall reduce the amount described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under subsection (b)(1)(B)) that are greater than the average cost for the covered drug for the year (as determined under section 1860D–16(b)(3)(A)).

''(d) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

''(e) DEFINITIONS.—In this section:

''(1) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

''(2) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled in this part and in a Medicare Prescription Drug plan;

''(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage); or

''(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan.

''(3) QUALIFYING ENTITY.—The term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

''(B) A MedicareAdvantage organization offering a MedicareAdvantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

''(C) The sponsor of a qualified retiree prescription drug plan.

''(4) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

''(A) IN GENERAL.—The term 'qualified retiree prescription drug plan' means employment-based retiree health coverage if, with respect to a qualifying covered individual who is covered under the plan, the following requirements are met:

''(i) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

''(ii) DISCLOSURE OF INFORMATION.—The sponsor complies with the requirements described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

''(B) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(5) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

''SEC. 1860D–21. (a) DIRECT SUBSIDY.—

''(1) IN GENERAL.—The Administrator shall provide for the payment to a sponsor of a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) for each qualifying covered individual (described in subparagraph (C) of section 1860D–20(e)(2)) enrolled in the plan for each month for which such individual is so enrolled.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the direct subsidy percent determined for the year of the monthly national average premium for the area for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(B) DIRECT SUBSIDY PERCENT.—For purposes of subparagraph (A), the term 'direct subsidy percent' means the percentage equal to—

''(i) 100 percent; minus

''(ii) the applicable percent for the year (as determined under section 1860D–17(c).

''(b) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

''Subpart 3—Miscellaneous Provisions

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860D–25. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the Account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

''(A) payments to eligible entities under section 1860D–16;

''(B) payments under 1860D–19 for low-income subsidy payments for cost-sharing;

''(C) reinsurance payments under section 1860D–20;

''(D) payments to sponsors of qualified retiree prescription drug plans under section 1860D–21;

''(E) payments to MedicareAdvantage organizations for the provision of qualified prescription drug coverage under section 1858A(c); and

''(F) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments and transfers made from the Account in the year.

''OTHER RELATED PROVISIONS

''SEC. 1860D–26. (a) RESTRICTION ON ENROLLMENT IN A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY A SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—

''(1) IN GENERAL.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that is a sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section), notwithstanding any other provision of this part and in accordance with regulations of the Administrator, the entity offering the plan may restrict the enrollment of eligible beneficiaries enrolled under this part to eligible beneficiaries who are enrolled in such coverage.

''(2) LIMITATION.—The sponsor of the employment-based retiree health coverage described in paragraph (1) may not offer enrollment in the Medicare Prescription Drug plan described in such paragraph based on the health status of eligible beneficiaries enrolled for such coverage.

''(b) COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

''(1) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), may enter into an agreement with a State pharmaceutical assistance program described in paragraph (2) to coordinate the coverage provided under the plan with the assistance provided under the State pharmaceutical assistance program.

''(2) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DESCRIBED.—For purposes of paragraph (1), a State pharmaceutical assistance program described in this paragraph is a program that has been established pursuant to a waiver under section 1115 or otherwise.

''(c) REGULATIONS TO CARRY OUT THIS PART.—

''(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing this part in interim final form without prior opportunity for public comment.

''(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).''.

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D–25'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),'';

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

(c) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(d) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) STUDY.—The Administrator of the Center for Medicare Choices (as established under section 1808 of the Social Security Act, as added by section 301(a)) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) REPORT.—Not later than January 1, 2005, the Administrator of the Center for Medicare Choices shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

''(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO PART D ENROLLEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

''(B) PENALTIES.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

''(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POLICYHOLDER OBTAINS PRESCRIPTION DRUG COVERAGE UNDER PART D.—

''(A) IN GENERAL.—The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F' (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)), or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the open enrollment period established under section 1860D–2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in the medicare prescription drug delivery program under part D; and

''(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' (including the benefit package classified as 'J' with a high deductible feature, as described in section 1882(p)(11)) under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

''(C) ENFORCEMENT.—The provisions of subparagraph (A) shall be enforced as though they were included in subsection (s).

''(3) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG COVERAGE.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D–2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

''(A) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

''(B) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D.''.

(b) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

SEC. 104. MEDICAID AND OTHER AMENDMENTS RELATED TO LOW-INCOME BENEFICIARIES.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (64);

(2) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(3) by inserting after paragraph (65) the following new paragraph:

''(66) provide for making eligibility determinations under section 1935(a).''.

(b) NEW SECTION.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall satisfy the following:

''(1) DETERMINATION OF ELIGIBILITY FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—For purposes of section 1807A, submit to the Secretary an eligibility plan under which the State—

''(A) establishes eligibility standards consistent with the provisions of that section;

''(B) establishes procedures for providing presumptive eligibility for eligible low-income beneficiaries (as defined in section 1807A(i)(2)) under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

''(C) makes determinations of eligibility and income for purposes of identifying eligible low-income beneficiaries (as so defined) under that section; and

''(D) communicates to the Secretary determinations of eligibility or discontinuation of eligibility under that section for purposes of notifying prescription drug card sponsors under that section of the identity of eligible medicare low-income beneficiaries.

''(2) DETERMINATION OF ELIGIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER PART D OF TITLE XVIII FOR LOW-INCOME INDIVIDUALS.—Beginning November 1, 2005, for purposes of section 1860D–19—

''(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with such section;

''(B) establish procedures for providing presumptive eligibility for individuals eligible for subsidies under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

''(C) inform the Administrator of the Center for Medicare Choices of such determinations in cases in which such eligibility is established; and

''(D) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–19).

''(3) AGREEMENT TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY

FIELD OFFICES.—Enter into an agreement with the Commissioner of Social Security to use all Social Security field offices located in the State as information and enrollment sites for making the eligibility determinations required under paragraphs (1) and (2).

''(b) FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—

''(1) ENHANCED MATCH FOR ELIGIBILITY DETERMINATIONS.—Subject to paragraphs (2) and (4), with respect to calendar quarters beginning on or after January 1, 2004, the amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under section 1903(a)(7) except that, in applying such section with respect to such expenditures incurred for—

''(A) such calendar quarters occurring in fiscal year 2004 or 2005, '75 percent' shall be substituted for '50 per centum';

''(B) calendar quarters occurring in fiscal year 2006, '70 percent' shall be substituted for '50 per centum';

''(C) calendar quarters occurring in fiscal year 2007, '65 percent' shall be substituted for '50 per centum'; and

''(D) calendar quarters occurring in fiscal year 2008 or any fiscal year thereafter, '60 percent' shall be substituted for '50 per centum'.

''(2) 100 PERCENT MATCH FOR ELIGIBILITY DETERMINATIONS FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—In the case of amounts expended by a State on or after November 1, 2005, to determine whether an individual is a subsidy-eligible individual for purposes of section 1860D–19, such expenditures shall be reimbursed under section 1903(a)(7) by substituting '100 percent' for '50 per centum'.

''(3) ENHANCED MATCH FOR UPDATES OR IMPROVEMENTS TO ELIGIBILITY DETERMINATION SYSTEMS.—With respect to calendar quarters occurring in fiscal year 2004, 2005, or 2006, the Secretary, in addition to amounts otherwise paid under section 1903(a), shall pay to each State which has a plan approved under this title, for each such quarter an amount equal to 90 percent of so much of the sums expended during such quarter as are attributable to the design, development, acquisition, or installation of improved eligibility determination systems (including hardware and software for such systems) in order to carry out the requirements of subsection (a) and section 1807A(h)(1) and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c). No payment shall be made to a State under the preceding sentence unless the State's improved eligibility determination system—

''(A) satisfies such standards for improvement as the Secretary may establish; and

''(B) complies, and is compatible, with the standards established under part C of title XI and any regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

''(4) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate expenditures described in paragraph (1), (2), or (3) that may otherwise be made for similar eligibility determinations or expenditures.

''(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

''(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f)) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

''(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

''(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

''(i) 2006 is 100 percent;

''(ii) 2007 is 95 percent;

''(iii) 2008 or 2009, is 90 percent;

''(iv) 2010 is 85 percent; or

''(v) 2011, 2012, or 2013 is 80 percent.

''(d) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan.

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

''(A) the previous provisions of this section shall not apply to residents of such State; and

''(B) if the State establishes a plan described in paragraph (2), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be further increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered drugs (as defined in section 1860D(a)(2)) to individuals described in subparagraph (A), (B), (C), or (D) of section 1860D–19(a)(3); and

''(B) ensures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a fiscal year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) the last 3 quarters of fiscal year 2006, is equal to $22,500,000;

''(ii) fiscal year 2007, is equal to $30,000,000; and

''(iii) any subsequent fiscal year, is equal to the aggregate amount specified in this subparagraph for the previous fiscal year increased by the annual percentage increase specified in section 1860D–6(c)(5) for the calendar year beginning in such fiscal year.

''(4) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State described in paragraph (1) for purposes of providing medical assistance described in paragraph (2)(A).

''(5) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

''(f) DEFINITION.—For purposes of this section, the term 'subsidy-eligible individual' has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).''.

(C) CONFORMING AMENDMENTS.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(c)(1) for the State and the quarter''.

(2) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

(4) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)), as amended by section 111(b), is amended—

(A) by striking ''and'' at the end of subclause (IV);

(B) by striking the period at the end of subclause (V) and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(VI) any prices charged which are negotiated under a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a MedicareAdvantage plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3).''.

(c) EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH 2008.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as follows:

''(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2008) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;''.

(2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(c) (42 U.S.C. 1396u–3(c)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E)—

(I) by striking ''fiscal year 2002'' and inserting ''each of fiscal years 2002 through 2008''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(F) the first quarter of fiscal year 2009, $100,000,000.''; and

(B) in paragraph (2)(A), by striking ''the sum of'' and all that follows through ''1902(a)(10)(E)(iv)(II) in the State; to'' and

inserting ''twice the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to''.

(d) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b–14) is amended—

(1) in the section heading, by inserting ''AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII'' after ''COST-SHARING'';

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting ''for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies under section 1860D–19'' before the semicolon; and

(ii) in subparagraph (B), by inserting '', program, and subsidies'' after ''medical assistance''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting '', the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19'' after ''assistance''; and

(ii) in subparagraph (A), by striking ''such eligibility'' and inserting ''eligibility for medicare cost-sharing under the medicaid program''; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting '', for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies for low-income individuals under section 1860D–19'' after ''1933''; and

(B) in paragraph (2), by inserting '', program, and subsidies'' after ''medical assistance''.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2005.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.''.

SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING AND DRUG UTILIZATION.

(a) STUDY.—The Secretary shall study on an ongoing basis variations in spending and drug utilization under part D of title XVIII of the Social Security Act for covered drugs to determine the impact of such variations on premiums imposed by eligible entities offering Medicare Prescription Drug plans under that part. In conducting such study, the Secretary shall examine the impact of geographic adjustments of the monthly national average premium under section 1860D–15 of such Act on—

(1) maximization of competition under part D of title XVIII of such Act; and

(2) the ability of eligible entities offering Medicare Prescription Drug plans to contain costs for covered drugs.

(b) REPORT.—Beginning with 2007, the Secretary shall submit annual reports to Congress on the study required under subsection (a).

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

SEC. 111. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new sections:

''MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

''SEC. 1807. (a) ESTABLISHMENT.—There is established a medicare prescription drug discount card endorsement program under which the Secretary shall—

''(1) endorse prescription drug discount card programs offered by prescription drug card sponsors that meet the requirements of this section; and

''(2) make available to eligible beneficiaries information regarding such endorsed programs.

''(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

''(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish procedures—

''(i) for identifying eligible beneficiaries; and

''(ii) under which such beneficiaries may make an election to enroll in any prescription drug discount card program endorsed under this section and disenroll from such a program.

''(B) LIMITATION.—An eligible beneficiary may not be enrolled in more than 1 prescription drug discount card program at any time.

''(2) ENROLLMENT FEES.—

''(A) IN GENERAL.—A prescription drug card sponsor may charge an annual enrollment fee to each eligible beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

''(B) AMOUNT.—No enrollment fee charged under subparagraph (A) may exceed $25.

''(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is the same for all eligible medicare beneficiaries enrolled in the program.

''(D) COLLECTION.—Any enrollment fee shall be collected by the prescription drug card sponsor.

''(c) PROVIDING INFORMATION TO ELIGIBLE BENEFICIARIES.—

''(1) PROMOTION OF INFORMED CHOICE.—

''(A) BY THE SECRETARY.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs. Such dissemination shall be coordinated with the dissemination of educational information on other medicare options.

''(B) BY PRESCRIPTION DRUG CARD SPONSORS.—Each prescription drug card sponsor shall make available to each eligible beneficiary (through the Internet and otherwise) information—

''(i) that the Secretary identifies as being necessary to promote informed choice among endorsed prescription drug discount card programs by eligible beneficiaries, including information on enrollment fees, negotiated prices for prescription drugs charged to beneficiaries, and services relating to prescription drugs offered under the program;

''(ii) on how any formulary used by such sponsor functions.

''(2) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1–800–MEDICARE toll free telephone number for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established under this section and prescription drug discount card programs endorsed under such program.

''(d) BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Each prescription drug discount card program endorsed under this section shall meet such requirements as the Secretary identifies to protect and promote the interest of eligible beneficiaries, including requirements that—

''(A) relate to appeals by eligible beneficiaries and marketing practices; and

''(B) ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

''(2) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(3) QUALITY ASSURANCE.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall have in place adequate procedures for assuring that quality service is provided to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor.

''(4) CONFIDENTIALITY OF ENROLLEE RECORDS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(5) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under subsection (b)(2)(A).

''(6) PRICES.—

''(A) AVOIDANCE OF HIGH PRICED DRUGS.—A prescription drug card sponsor may not recommend switching an eligible beneficiary to a drug with a higher negotiated price absent a recommendation by a licensed health professional that there is a clinical indication with respect to the patient for such a switch.

''(B) PRICE STABILITY.—Negotiated prices charged for prescription drugs covered under

a prescription drug discount card program endorsed under this section may not change more frequently than once every 60 days.

''(e) PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Each prescription drug card sponsor may only provide benefits that relate to prescription drugs (as defined in subsection (i)(2)) under a prescription drug discount card program endorsed under this section.

''(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

''(A) IN GENERAL.—Subject to subparagraph (D), each prescription drug card sponsor shall provide eligible beneficiaries who enroll in a prescription drug discount card program offered by such sponsor that is endorsed under this section with access to negotiated prices used by the sponsor with respect to prescription drugs dispensed to eligible beneficiaries.

''(B) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The requirements of section 1927 relating to manufacturer best price shall not apply to the negotiated prices for prescription drugs made available under a prescription drug discount card program endorsed under this section.

''(C) GUARANTEED ACCESS TO NEGOTIATED PRICES.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures to ensure that eligible beneficiaries have access to the negotiated prices for prescription drugs provided under subparagraph (A).

''(D) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card program if the program excludes the drug under a formulary.

''(3) BENEFICIARY SERVICES.—Each prescription drug discount card program endorsed under this section shall provide pharmaceutical support services, such as education, counseling, and services to prevent adverse drug interactions.

''(4) DISCOUNT CARDS.—Each prescription drug card sponsor shall issue a card to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor that the beneficiary may use to obtain benefits under the program.

''(f) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT AND APPROVAL.—

''(1) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

''(2) APPROVAL.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to endorse the prescription drug discount card program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

''(g) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a prescription drug card sponsor offering a prescription drug discount card program uses a formulary, the following requirements must be met:

''(1) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

''(A) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

''(B) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

''(2) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

''(A) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (as defined by the Secretary), although not necessarily for all drugs within such categories and classes.

''(B) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutic categories and classes.

''(4) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(5) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and pharmacies.

''(h) FRAUD AND ABUSE PREVENTION.—

''(1) IN GENERAL.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

''(2) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions and may revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

''(3) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for any violation of this section. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(4) REPORTING TO SECRETARY.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall report information relating to program performance, use of prescription drugs by eligible beneficiaries enrolled in the program, financial information of the sponsor, and such other information as the Secretary may specify. The Secretary may not disclose any proprietary data reported under this paragraph.

''(5) DRUG UTILIZATION REVIEW.—The Secretary may use claims data from parts A and B for purposes of conducting a drug utilization review program.

''(i) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means an individual who—

''(i) is entitled to, or enrolled for, benefits under part A and enrolled under part B; and

''(ii) is not a dual eligible individual (as defined in subparagraph (B)).

''(B) DUAL ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'dual eligible individual' means an individual who is—

''(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that includes but is limited solely to covered outpatient drugs (as such term is defined for purposes of section 1927); and

''(II) entitled to benefits under part A and enrolled under part B.

''(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

''(2) PRESCRIPTION DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'prescription drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

''(ii) a biological product or insulin described in subparagraph (B) or (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—The term 'prescription drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(3) NEGOTIATED PRICE.—The term 'negotiated price' includes all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations.

''(4) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' means any entity with demonstrated experience and expertise in operating a prescription drug discount card program, an insurance program that provides coverage for prescription drugs, or a similar program that the Secretary determines to be appropriate to provide eligible beneficiaries with the benefits under a prescription drug discount card program endorsed by the Secretary under this section, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) any other entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES

''SEC. 1807A. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is established a program under which the Secretary shall award contracts to prescription drug card sponsors offering a prescription drug discount card that has been endorsed by the Secretary under section 1807 under which such sponsors shall offer a prescription drug assistance card program to eligible low-income beneficiaries in accordance with the requirements of this section.

''(2) APPLICATION OF DISCOUNT CARD PROVISIONS.—Except as otherwise provided in this section, the provisions of section 1807 shall apply to the program established under this section.

''(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

''(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the enrollment procedures established under section 1807(b)(1)(A)(ii) shall apply for purposes of this section.

''(B) ENROLLMENT OF ANY ELIGIBLE LOW-INCOME BENEFICIARY.—Each prescription drug card sponsor offering a prescription drug assistance card program under this section shall permit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

''(C) SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—An eligible low-income beneficiary who enrolls in a prescription drug assistance card program offered by a prescription drug card sponsor under this section shall be simultaneously enrolled in a prescription drug discount card program offered by such sponsor.

''(2) WAIVER OF ENROLLMENT FEES.—

''(A) IN GENERAL.—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

''(B) PAYMENT BY SECRETARY.—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fee charged under section 1807(b)(2)(A) on behalf of each eligible low-income beneficiary enrolled in a prescription drug discount card program under paragraph (1)(C) offered by such sponsor.

''(c) ADDITIONAL BENEFICIARY PROTECTIONS.—

''(1) PROVIDING INFORMATION TO ELIGIBLE LOW-INCOME BENEFICIARIES.—In addition to the information provided to eligible beneficiaries under section 1807(c), the prescription drug card sponsor shall—

''(A) periodically notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the amount of coverage for prescription drugs remaining under subsection (d)(2)(A); and

''(B) notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the grievance and appeals processes under the program.

''(2) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—For purposes of determining whether convenient access has been provided under section 1807(d)(2) with respect to eligible low-income beneficiaries enrolled in a prescription drug assistance card program, the Secretary may only make a determination that such access has been provided if an appropriate arrangement is in place for eligible low-income beneficiaries who are in a long-term care facility (as defined by the Secretary) to receive prescription drug benefits under the program.

''(3) COORDINATION OF BENEFITS.—

''(A) IN GENERAL.—The Secretary shall establish procedures under which eligible low-income beneficiaries who are enrolled for coverage described in subparagraph (B) and enrolled in a prescription drug assistance card program have access to the prescription drug benefits available under such program.

''(B) COVERAGE DESCRIBED.—Coverage described in this subparagraph is as follows:

''(i) Coverage of prescription drugs under a State pharmaceutical assistance program.

''(ii) Enrollment in a Medicare+Choice plan under part C.

''(4) GRIEVANCE MECHANISM.—Each prescription drug card sponsor with a contract under this section shall provide in accordance with section 1852(f) meaningful procedures for hearing and resolving grievances between the prescription drug card sponsor (including any entity or individual through which the prescription drug card sponsor provides covered benefits) and enrollees in a prescription drug assistance card program offered by such sponsor.

''(5) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—

''(A) IN GENERAL.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply with respect to covered benefits under a prescription drug assistance card program under this section in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug assistance card program offered by a prescription drug card sponsor that provides for tiered pricing for drugs included within a formulary and provides lower prices for preferred drugs included within the formulary, an eligible low-income beneficiary who is enrolled in the program may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(C) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(6) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), a prescription drug card sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in a similar manner (as determined by the Secretary) as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The prescription drug card sponsor must have, as part of the appeals process under this paragraph, a process for timely appeals for denials of coverage based on the application of the formulary.

''(d) PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Subject to paragraph (5), all the benefits available under a prescription drug discount card program offered by a prescription drug card sponsor and endorsed under section 1807 shall be available to eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor.

''(2) ASSISTANCE FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—

''(A) $600 ANNUAL ASSISTANCE.—Subject to subparagraphs (B) and (C) and paragraph (5), each prescription drug card sponsor with a contract under this section shall provide coverage for the first $600 of expenses for prescription drugs incurred during each calendar year by an eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor.

''(B) COINSURANCE.—

''(i) IN GENERAL.—The prescription drug card sponsor shall determine an amount of coinsurance to collect from each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor for which coverage is available under subparagraph (A).

''(ii) AMOUNT.—The amount of coinsurance collected under clause (i) shall be at least 10 percent of the negotiated price of each prescription drug dispensed to an eligible low-income beneficiary.

''(iii) CONSTRUCTION.—Amounts collected under clause (i) shall not be counted against the total amount of coverage available under subparagraph (A).

''(C) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible low-income beneficiary is not enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor with a contract under this section, the amount of assistance available under subparagraph (A) shall be reduced by $50.

''(D) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—The dollar amount of coverage described in subparagraph (A) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

''(E) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Secretary may waive such requirements of this section and section 1807 as may be necessary to ensure that each eligible low-income beneficiaries has access to the assistance described in subparagraph (A).

''(3) ADDITIONAL DISCOUNTS.—A prescription drug card sponsor with a contract under this section shall provide each eligible low-income beneficiary enrolled in a prescription drug assistance program offered by the sponsor with access to negotiated prices that reflect a minimum average discount of at least 20 percent of the average wholesale price for prescription drugs covered under that program.

''(4) ASSISTANCE CARDS.—Each prescription drug card sponsor shall permit eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor to use the discount card issued under section 1807(e)(4) to obtain benefits under the program.

''(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible low-income beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug assistance card program if the program excludes the drug under a formulary and such exclusion is not successfully resolved under paragraph (4), (5), or (6) of subsection (c).

''(e) REQUIREMENTS FOR PRESCRIPTION DRUG CARD SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE CARD PROGRAMS.—

''(1) IN GENERAL.—Each prescription drug card sponsor shall—

''(A) process claims made by eligible low-income beneficiaries;

''(B) negotiate with brand name and generic prescription drug manufacturers and others for low prices on prescription drugs;

''(C) track individual beneficiary expenditures in a format and periodicity specified by the Secretary; and

''(D) perform such other functions as the Secretary may assign.

''(2) DATA EXCHANGES.—Each prescription drug card sponsor shall receive data exchanges in a format specified by the Secretary and shall maintain real-time beneficiary files.

''(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The prescription drug card sponsor offering the prescription drug assistance card program shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the eligible low-income beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest priced generic drug covered under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy or other dispenser.

''(f) SUBMISSION OF BIDS AND AWARDING OF CONTRACTS.—

''(1) SUBMISSION OF BIDS.—Each prescription drug card sponsor that seeks to offer a prescription drug assistance card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

''(2) AWARDING OF CONTRACTS.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to award a contract to the prescription drug card sponsor offering the program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

''(3) NUMBER OF CONTRACTS.—There shall be no limit on the number of prescription drug card sponsors that may be awarded contracts under paragraph (2).

''(4) CONTRACT PROVISIONS.—

''(A) DURATION.—A contract awarded under paragraph (2) shall be for the lifetime of the program under this section.

''(B) WITHDRAWAL.—A prescription drug card sponsor that desires to terminate the contract awarded under paragraph (2) may terminate such contract without penalty if such sponsor gives notice—

''(i) to the Secretary 90 days prior to the termination of such contract; and

''(ii) to each eligible low-income beneficiary that is enrolled in a prescription drug assistance card program offered by such sponsor 60 days prior to such termination.

''(C) SERVICE AREA.—The service area under the contract shall be the same as the area served by the prescription drug card sponsor under section 1807.

''(5) SIMULTANEOUS APPROVAL OF DISCOUNT CARD AND ASSISTANCE PROGRAMS.—A prescription drug card sponsor may submit an application for endorsement under section 1807 as part of the bid submitted under paragraph (1) and the Secretary may approve such application at the same time as the Secretary awards a contract under this section.

''(g) PAYMENTS TO PRESCRIPTION DRUG CARD SPONSORS.—

''(1) IN GENERAL.—The Secretary shall pay to each prescription drug card sponsor offering a prescription drug assistance card program in which an eligible low-income beneficiary is enrolled an amount equal to the amount agreed to by the Secretary and the sponsor in the contract awarded under subsection (f)(2).

''(2) PAYMENT FROM PART B TRUST FUND.—The costs of providing benefits under this section shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''(h) ELIGIBILITY DETERMINATIONS MADE BY STATES; PRESUMPTIVE ELIGIBILITY.—States shall perform the functions described in section 1935(a)(1).

''(i) APPROPRIATIONS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 such sums as may be necessary to carry out the program under this section.

''(j) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY; NEGOTIATED PRICE; PRESCRIPTION DRUG.—The terms 'eligible beneficiary', 'negotiated price', and 'prescription drug' have the meanings given those terms in section 1807(i).

''(2) ELIGIBLE LOW-INCOME BENEFICIARY.—The term 'eligible low-income beneficiary' means an individual who—

''(A) is an eligible beneficiary (as defined in section 1807(i));

''(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and

''(C) is described in clause (iii) or (iv) of section 1902(a)(10)(E) or in section 1905(p)(1).

''(3) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' has the meaning given that term in section 1807(i), except that such sponsor shall also be an entity that the Secretary determines is—

''(A) is appropriate to provide eligible low-income beneficiaries with the benefits under a prescription drug assistance card program under this section; and

''(B) is able to manage the monetary assistance made available under subsection (d)(2);

''(C) agrees to submit to audits by the Secretary; and

''(D) provides such other assurances as the Secretary may require.

''(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX.''.

(b) EXCLUSION OF PRICES FROM DETERMINATION OF BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking ''and'' at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(V) any negotiated prices charged under the medicare prescription drug discount card endorsement program under section 1807 or under the transitional prescription drug assistance card program for eligible low-income beneficiaries under section 1807A.''.

(c) EXCLUSION OF PRESCRIPTION DRUG ASSISTANCE CARD COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(2) the prescription drug assistance card program under section 1807A.''.

(d) REGULATIONS.—

(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing sections 1807 and 1807A of the Social Security Act (as added by this section) in interim final form without prior opportunity for public comment.

(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).

(3) EXEMPTION FROM THE PAPERWORK REDUCTION ACT.—The promulgation of the regulations under this subsection and the administration the programs established by sections 1807 and 1807A of the Social Security Act (as added by this section) shall be made without regard to chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'').

(e) IMPLEMENTATION; TRANSITION.—

(1) IMPLEMENTATION.—The Secretary shall implement the amendments made by this section in a manner that discounts are available to eligible beneficiaries under section 1807 of the Social Security Act and assistance is available to eligible low-income beneficiaries under section 1807A of such Act not later than January 1, 2004.

(2) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the programs under section 1807 and 1807A of the Social Security Act. Such transition and discontinuation shall ensure that such programs continue to operate until the date on which the first enrollment period under part D ends.

Subtitle C—Standards for Electronic Prescribing

SEC. 121. STANDARDS FOR ELECTRONIC PRESCRIBING.

Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—ELECTRONIC PRESCRIBING

''STANDARDS FOR ELECTRONIC PRESCRIBING

''SEC. 1180. (a) STANDARDS.—

''(1) DEVELOPMENT AND ADOPTION.—

''(A) IN GENERAL.—The Secretary shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as 'standards') to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information.

''(B) CONSULTATION.—In developing and adopting the standards under subparagraph (A), the Secretary shall consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiary information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

''(2) OBJECTIVE.—Any standards developed or adopted under this part shall be consistent with the objectives of improving—

''(A) patient safety; and

''(B) the quality of care provided to patients.

''(3) REQUIREMENTS.—Any standards developed or adopted under this part shall comply with the following:

''(A) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the standards require that prescriptions be written and transmitted electronically.

''(ii) EXCEPTIONS.—The standards shall not require a prescription to be written and transmitted electronically—

''(I) in emergency cases and other exceptional circumstances recognized by the Administrator; or

''(II) if the patient requests that the prescription not be transmitted electronically.

If a patient makes a request under subclause (II), no additional charges may be imposed on the patient for making such request.

''(B) PATIENT-SPECIFIC MEDICATION HISTORY, ELIGIBILITY, BENEFIT, AND OTHER PRESCRIPTION INFORMATION.—

''(i) IN GENERAL.—The standards shall accommodate electronic transmittal of patient-specific medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care.

''(ii) REQUIRED INFORMATION.—The information described in clause (i) shall include the following:

''(I) Information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medication history of the patient that may be relevant to the appropriate prescription for that patient.

''(II) Cost-effective alternatives (if any) to the drug prescribed.

''(III) Information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization.

''(IV) Information on potential interactions with drugs listed on the medication history, graded by severity of the potential interaction.

''(V) Other information to improve the quality of patient care and to reduce medical errors.

''(C) UNDUE BURDEN.—The standards shall be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on the practice of medicine, pharmacy, or other health professions.

''(D) COMPATIBILITY WITH ADMINISTRATIVE SIMPLIFICATION AND PRIVACY LAWS.—The standards shall be—

''(i) consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

''(ii) compatible with the standards adopted under part C.

''(4) TRANSFER OF INFORMATION.—The Secretary shall develop and adopt standards for transferring among prescribing and insurance entities and other necessary entities appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

''(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

''(1) IN GENERAL.—The Secretary shall adopt the standards under this part by January 1, 2006.

''(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—The Secretary shall, in consultation with appropriate representatives of interested parties, review the standards developed or adopted under this part and adopt modifications to the standards (including additions to the standards), as determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(c) COMPLIANCE WITH STANDARDS.—

''(1) REQUIREMENT FOR ALL INDIVIDUALS AND ENTITIES THAT TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—

''(A) IN GENERAL.—Individuals or entities that transmit or receive electronic medication history, eligibility, benefit and prescription information, shall comply with the standards adopted or modified under this part.

''(B) RELATION TO STATE LAWS.—The standards adopted or modified under this part shall supersede any State law or regulations pertaining to the electronic transmission of medication history, eligibility, benefit and prescription information.

''(2) TIMETABLE FOR COMPLIANCE.—

''(A) INITIAL COMPLIANCE.—

''(i) IN GENERAL.—Not later than 24 months after the date on which an initial standard is adopted under this part, each individual or entity to whom the standard applies shall comply with the standard.

''(ii) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, as defined by the Secretary for purposes of section 1175(b)(1)(B), clause (i) shall be applied by substituting '36 months' for '24 months'.

''(d) CONSULTATION WITH ATTORNEY GENERAL.—The Secretary shall consult with the Attorney General before developing, adopting, or modifying a standard under this part to ensure that the standard accommodates secure electronic transmission of prescriptions for controlled substances in a manner that minimizes the possibility of violations under the Comprehensive Drug Abuse Prevention and Control Act of 1970 and related Federal laws.

''GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION PROGRAMS

''SEC. 1180A. (a) IN GENERAL.—The Secretary is authorized to make grants to health care providers for the purpose of assisting such entities to implement electronic prescription programs that comply with the standards adopted or modified under this part.

''(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.''.

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.

Section 1851 (42 U.S.C. 1395w–21) is amended to read as follows:

''ELIGIBILITY, ELECTION, AND ENROLLMENT

''SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREADVANTAGE PLANS.—

''(1) IN GENERAL.—Subject to the provisions of this section, each MedicareAdvantage eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

''(A) through—

''(i) the original Medicare fee-for-service program under parts A and B; and

''(ii) the voluntary prescription drug delivery program under part D; or

''(B) through enrollment in a MedicareAdvantage plan under this part.

''(2) TYPES OF MEDICAREADVANTAGE PLANS THAT MAY BE AVAILABLE.—A MedicareAdvantage plan may be any of the following types of plans of health insurance:

''(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans (with or without point of service options) and plans offered by provider-sponsored organizations (as defined in section 1855(d)).

''(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREADVANTAGE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a MedicareAdvantage medical savings account (MSA).

''(C) PRIVATE FEE-FOR-SERVICE PLANS.—A MedicareAdvantage private fee-for-service plan, as defined in section 1859(b)(2).

''(3) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—Subject to subparagraph (B), in this title, the term 'MedicareAdvantage eligible individual' means an individual who is entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

''(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice or a MedicareAdvantage plan may continue to be enrolled in that plan; and

''(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan or a MedicareAdvantage plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a 'MedicareAdvantage eligible individual' for purposes of electing to continue enrollment in another MedicareAdvantage plan.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—

''(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization only if the plan serves the geographic area in which the individual resides.

''(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1852(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost-sharing liability in obtaining such benefits.

''(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a MedicareAdvantage organization eliminates from its service area a MedicareAdvantage payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a MedicareAdvantage plan it offers so long as—

''(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

''(ii) there is no other MedicareAdvantage plan offered in the area in which the enrollee resides at the time of the organization's election.

''(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS.—

''(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

''(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

''(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working

individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

''(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

''(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

''(i) on or after January 1, 2004, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

''(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

''(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

''(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

''(c) PROCESS FOR EXERCISING CHOICE.—

''(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

''(2) COORDINATION THROUGH MEDICAREADVANTAGE ORGANIZATIONS.—

''(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization to make such election through the filing of an appropriate election form with the organization.

''(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicareAdvantage plan offered by a MedicareAdvantage organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

''(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a Medicare+Choice plan or another health plan (other than a MedicareAdvantage plan) offered by a MedicareAdvantage organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicareAdvantage plan offered by the organization (or, if the organization offers more than 1 such plan, such plan or plans as the Secretary identifies under such procedures).

''(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

''(i) the individual changes the election under this section; or

''(ii) the MedicareAdvantage plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

''(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

''(2) PROVISION OF NOTICE.—

''(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicareAdvantage eligible individual residing in an area the following:

''(i) GENERAL INFORMATION.—The general information described in paragraph (3).

''(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicareAdvantage plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

''(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

''(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial MedicareAdvantage enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

''(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

''(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicareAdvantage plans, the benefits under such plans, and the MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage for such plans.

''(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

''(A) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under parts A and B of the original medicare fee-for-service program, including—

''(i) covered items and services;

''(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

''(iii) any beneficiary liability for balance billing.

''(B) CATASTROPHIC COVERAGE AND COMBINED DEDUCTIBLE.—A description of the catastrophic coverage and unified deductible applicable under the plan.

''(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—The information required under section 1860D–4 with respect to coverage for prescription drugs under the plan.

''(D) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

''(E) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program (including such rights under part D) and the MedicareAdvantage program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

''(F) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

''(G) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicareAdvantage organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the MedicareAdvantage plan under this part.

''(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicareAdvantage plan for a year, shall include the following:

''(A) BENEFITS.—The benefits covered under the plan, including the following:

''(i) Covered items and services beyond those provided under the original medicare fee-for-service program option.

''(ii) Beneficiary cost-sharing for any items and services described in clause (i) and paragraph (3)(A)(i), including information on the unified deductible under section 1852(a)(1)(C).

''(iii) The maximum limitations on out-of-pocket expenses under section 1852(a)(1)(C).

''(iv) In the case of an MSA plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

''(v) In the case of a MedicareAdvantage private fee-for-service plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

''(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

''(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

''(viii) The organization's coverage of emergency and urgently needed care.

''(ix) The comparative information described in section 1860D–4(b)(2) relating to prescription drug coverage under the plan.

''(B) PREMIUMS.—

''(i) IN GENERAL.—The MedicareAdvantage monthly basic beneficiary premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, if any, for the plan or, in the case of an MSA plan, the MedicareAdvantage monthly MSA premium.

''(ii) REDUCTIONS.—The reduction in part B premiums, if any.

''(iii) NATURE OF THE PREMIUM FOR ENHANCED MEDICAL BENEFITS.—Whether the MedicareAdvantage monthly premium for enhanced benefits is optional or mandatory.

''(C) SERVICE AREA.—The service area of the plan.

''(D) QUALITY AND PERFORMANCE.—Plan quality and performance indicators for the

benefits under the plan (and how such indicators compare to quality and performance indicators under the original medicare fee-for-service program under parts A and B and under the voluntary prescription drug delivery program under part D in the area involved), including—

''(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area);

''(ii) information on medicare enrollee satisfaction;

''(iii) information on health outcomes; and

''(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

''(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicareAdvantage options and the operation of this part in all areas in which MedicareAdvantage plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicareAdvantage plans.

''(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

''(7) PROVISION OF INFORMATION.—A MedicareAdvantage organization shall provide the Secretary with such information on the organization and each MedicareAdvantage plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes eligible to elect to receive benefits under part B or D (whichever is later), there is 1 or more MedicareAdvantage plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a MedicareAdvantage plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

''(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), the following rules shall apply:

''(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

''(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a MedicareAdvantage eligible individual during 2006, during the first 6 months during 2006 in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF 1 CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

''(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 3 months of 2007 and each subsequent year, or, if the individual first becomes a MedicareAdvantage eligible individual during 2007 or any subsequent year, during the first 3 months of such year in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF 1 CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

''(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time during 2006 or any subsequent year, in the case of a MedicareAdvantage eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

''(i) to enroll in a MedicareAdvantage plan; or

''(ii) to change the MedicareAdvantage plan in which the individual is enrolled.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

''(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2006, the month of November before such year and with respect to 2003, 2004, 2005, and 2006, the period beginning on November 15 and ending on December 31 of the year before such year.

''(C) MEDICAREADVANTAGE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 2006), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicareAdvantage eligible individuals about MedicareAdvantage plans and the election process provided under this section.

''(D) SPECIAL INFORMATION CAMPAIGN IN 2005.—During the period beginning on November 15, 2005, and ending on December 31, 2005, the Secretary shall provide for an educational and publicity campaign to inform MedicareAdvantage eligible individuals about the availability of MedicareAdvantage plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section.

''(4) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual may discontinue an election of a MedicareAdvantage plan offered by a MedicareAdvantage organization other than during an annual, coordinated election period and make a new election under this section if—

''(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

''(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

''(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

''(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

''(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

''(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

''(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective on and after January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a MedicareAdvantage plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

''(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

''(A) may elect an MSA plan only during—

''(i) an initial open enrollment period described in paragraph (1);

''(ii) an annual, coordinated election period described in paragraph (3)(B); or

''(iii) the month of November 1998;

''(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

''(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

''(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a MedicareAdvantage organization—

''(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period beginning on November 15, 2005, and ending on December 31, 2005, and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

''(B) may accept other changes to elections at such other times as the organization provides.

''(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D, except as the Secretary may provide (consistent with sections 1838 and 1860D–2)) in order to prevent retroactive coverage.

''(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

''(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

''(g) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a MedicareAdvantage organization shall provide that at any time during which elections are accepted under this section with respect to a MedicareAdvantage plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

''(2) PRIORITY.—If the Secretary determines that a MedicareAdvantage organization, in relation to a MedicareAdvantage plan it offers, has a capacity limit and the number of MedicareAdvantage eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

''(A) first to such individuals as have elected the plan at the time of the determination; and

''(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

''(3) LIMITATION ON TERMINATION OF ELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), a MedicareAdvantage organization may not for any reason terminate the election of any individual under this section for a MedicareAdvantage plan it offers.

''(B) BASIS FOR TERMINATION OF ELECTION.—A MedicareAdvantage organization may terminate an individual's election under this section with respect to a MedicareAdvantage plan it offers if—

''(i) any MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, or MedicareAdvantage monthly beneficiary premium for required or optional enhanced medical benefits required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums);

''(ii) the individual has engaged in disruptive behavior (as specified in such standards); or

''(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

''(C) CONSEQUENCE OF TERMINATION.—

''(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected to receive benefits under the original medicare fee-for-service program option.

''(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicareAdvantage plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option.

''(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857858., each MedicareAdvantage organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

''(1) SUBMISSION.—No marketing material or application form may be distributed by a MedicareAdvantage organization to (or for the use of) MedicareAdvantage eligible individuals unless—

''(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review; and

''(B) the Secretary has not disapproved the distribution of such material or form.

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a MedicareAdvantage plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicareAdvantage organization shall conform to fair marketing standards, in relation to MedicareAdvantage plans offered under this part, included in the standards established under section 1856. Such standards—

''(A) shall not permit a MedicareAdvantage organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in section 1854(g)(1)(C)(i)); and

''(B) may include a prohibition against a MedicareAdvantage organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

''(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

''(i) EFFECT OF ELECTION OF MEDICAREADVANTAGE PLAN OPTION.—

''(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a MedicareAdvantage organization under section 1853(a) with respect to an individual electing a MedicareAdvantage plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A, B, and D for items and services furnished to the individual.

''(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(f), 1853(h), 1853(i), 1857(f)(2), 1886(d)(11), and 1886(h)(3)(D), only the MedicareAdvantage organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.''.

SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.

Section 1852 (42 U.S.C. 1395w–22) is amended to read as follows:

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans, each MedicareAdvantage plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan;

''(B) except as provided in paragraph (2)(D), qualified prescription drug coverage under part D to individuals residing in the area served by the plan;

''(C) a maximum limitation on out-of-pocket expenses and a unified deductible; and

''(D) additional benefits required under section 1854(d)(1).

''(2) SATISFACTION OF REQUIREMENT.—

''(A) IN GENERAL.—A MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

''(i) the sum of such payment amount and any cost-sharing provided for under the plan; is equal to at least

''(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(B) REFERENCE TO RELATED PROVISIONS.—For provisions relating to—

''(i) limitations on balance billing against MedicareAdvantage organizations for non-contract providers, see sections 1852(k) and 1866(a)(1)(O); and

''(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(f).

''(C) ELECTION OF UNIFORM COVERAGE POLICY.—In the case of a MedicareAdvantage organization that offers a MedicareAdvantage plan in an area in which more than 1 local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to MedicareAdvantage enrollees (as identified by the Secretary) apply with respect to all MedicareAdvantage enrollees enrolled in the plan.

''(D) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—

''(i) IN GENERAL.—A private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

''(ii) AVAILABILITY OF DRUG COVERAGE FOR ENROLLEES.—If a beneficiary enrolls in a plan making the election described in clause (i),

the beneficiary may enroll for drug coverage under part D with an eligible entity under such part.

''(3) ENHANCED MEDICAL BENEFITS.—

''(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each MedicareAdvantage organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), enhanced medical benefits that the Secretary may approve. The Secretary shall approve any such enhanced medical benefits unless the Secretary determines that including such enhanced medical benefits would substantially discourage enrollment by MedicareAdvantage eligible individuals with the organization.

''(B) AT ENROLLEES' OPTION.—A MedicareAdvantage organization may not provide, under an MSA plan, enhanced medical benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

''(C) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a MedicareAdvantage private fee-for-service plan from offering enhanced medical benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

''(D) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any enhanced medical benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

''(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicareAdvantage organization may (in the case of the provision of items and services to an individual under a MedicareAdvantage plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services; or

''(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicareAdvantage organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the benchmark amount announced under section 1853(b)(1)(A) at the beginning of such period, then, unless otherwise required by law—

''(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period; and

''(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period. The projection under the previous sentence shall be based on an analysis by the Secretary of the actuarial costs associated with the coverage determination or legislative change in benefits.

''(6) AUTHORITY TO PROHIBIT RISK SELECTION.—The Secretary shall have the authority to disapprove any MedicareAdvantage plan that the Secretary determines is designed to attract a population that is healthier than the average population residing in the service area of the plan.

''(7) UNIFIED DEDUCTIBLE DEFINED.—In this part, the term 'unified deductible' means an annual deductible amount that is applied in lieu of the inpatient hospital deductible under section 1813(b)(1) and the deductible under section 1833(b). Nothing in this part shall be construed as preventing a MedicareAdvantage organization from requiring coinsurance or a copayment for inpatient hospital services after the unified deductible is satisfied, subject to the limitation on enrollee liability under section 1854(f).

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

''(A) IN GENERAL.—A MedicareAdvantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(B) CONSTRUCTION.—Except as provided under section 1851(a)(3)(B), subparagraph (A) shall not be construed as requiring a MedicareAdvantage organization to enroll individuals who are determined to have end-stage renal disease.

''(2) PROVIDERS.—A MedicareAdvantage organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(c) DISCLOSURE REQUIREMENTS.—

''(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicareAdvantage organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicareAdvantage plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

''(A) SERVICE AREA.—The plan's service area.

''(B) BENEFITS.—Benefits offered under the plan, including information described section 1852(a)(1) (relating to benefits under the original medicare fee-for-service program option, the maximum limitation in out-of-pocket expenses and the unified deductible, and qualified prescription drug coverage under part D, respectively) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicareAdvantage plans.

''(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits for such option).

''(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

''(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(ii) the process and procedures of the plan for obtaining emergency services; and

''(iii) the locations of—

''(I) emergency departments; and

''(II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(F) ENHANCED MEDICAL BENEFITS.—Enhanced medical benefits available from the organization offering the plan, including—

''(i) whether the enhanced medical benefits are optional;

''(ii) the enhanced medical benefits covered; and

''(iii) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits.

''(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

''(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

''(2) DISCLOSURE UPON REQUEST.—Upon request of a MedicareAdvantage eligible individual, a MedicareAdvantage organization must provide the following information to such individual:

''(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

''(B) Information on procedures used by the organization to control utilization of services and expenditures.

''(C) Information on the number of grievances, reconsiderations, and appeals and on the disposition in the aggregate of such matters.

''(D) An overall summary description as to the method of compensation of participating physicians.

''(E) The information described in subparagraphs (A) through (C) in relation to the qualified prescription drug coverage provided by the organization.

''(d) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A MedicareAdvantage organization offering a MedicareAdvantage plan may select the providers from whom the benefits under the plan are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

''(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

''(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were not emergency services (as defined in paragraph (3)), but—

''(I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

''(II) it was not reasonable given the circumstances to obtain the services through the organization;

''(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area; or

''(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

''(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

''(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicareAdvantage plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

''(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

''(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(i) are furnished by a provider that is qualified to furnish such services under this title; and

''(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

''(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

''(ii) serious impairment to bodily functions; or

''(iii) serious dysfunction of any bodily organ or part.

''(4) ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a MedicareAdvantage private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

''(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, B, or D for such services; or

''(B) the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan,

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

''(e) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each MedicareAdvantage organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicareAdvantage plans of the organization.

''(2) ELEMENTS OF PROGRAM.—

''(A) IN GENERAL.—The quality assurance program of an organization with respect to a MedicareAdvantage plan (other than a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan) it offers shall—

''(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicareAdvantage plans and organizations;

''(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

''(iii) provide access to disease management and chronic care services;

''(iv) provide access to preventive benefits and information for enrollees on such benefits;

''(v) evaluate the continuity and coordination of care that enrollees receive;

''(vi) be evaluated on an ongoing basis as to its effectiveness;

''(vii) include measures of consumer satisfaction;

''(viii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

''(ix) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(x) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

''(xi) have mechanisms to detect both underutilization and overutilization of services;

''(xii) after identifying areas for improvement, establish or alter practice parameters;

''(xiii) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

''(xiv) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

''(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS, AND NONNETWORK MSA PLANS.—The quality assurance program of an organization with respect to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan it offers shall—

''(i) meet the requirements of clauses (i) through (viii) of subparagraph (A);

''(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

''(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

''(C) DEFINITION OF NONNETWORK MSA PLAN.—In this subsection, the term 'nonnetwork MSA plan' means an MSA plan offered by a MedicareAdvantage organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

''(3) EXTERNAL REVIEW.—

''(A) IN GENERAL.—Each MedicareAdvantage organization shall, for each MedicareAdvantage plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (4)(B) and (14) of section 1154(a) with respect to services furnished by MedicareAdvantage plans for which payment is made under this title. The previous sentence shall not apply to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan that does not employ utilization review.

''(B) NONDUPLICATION OF ACCREDITATION.—Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

''(C) WAIVER AUTHORITY.—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

''(4) TREATMENT OF ACCREDITATION.—

''(A) IN GENERAL.—The Secretary shall provide that a MedicareAdvantage organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

''(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

''(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

''(ii) Subsection (b) (relating to antidiscrimination).

''(iii) Subsection (d) (relating to access to services).

''(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

''(v) Subsection (i) (relating to information on advance directives).

''(vi) Subsection (j) (relating to provider participation rules).

''(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

''(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857,

including the authority to terminate contracts with MedicareAdvantage organizations under subsection (c)(2) of such section.

''(5) REPORT TO CONGRESS.—

''(A) IN GENERAL.—The Secretary shall submit to Congress a biennial report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

''(B) CONTENTS OF REPORT.—Each such report shall include the following:

''(i) A description of the means by which such programs focus on such racial and ethnic minorities.

''(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

''(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

''(f) GRIEVANCE MECHANISM.—Each MedicareAdvantage organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with MedicareAdvantage plans of the organization under this part.

''(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) DETERMINATIONS BY ORGANIZATION.—

''(A) IN GENERAL.—A MedicareAdvantage organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

''(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

''(2) RECONSIDERATIONS.—

''(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

''(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

''(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—

''(i) ENROLLEE REQUESTS.—An enrollee in a MedicareAdvantage plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the MedicareAdvantage organization.

''(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The MedicareAdvantage organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) EXPEDITION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(iii) TIMELY RESPONSE.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

''(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

''(5) APPEALS.—An enrollee with a MedicareAdvantage plan of a MedicareAdvantage organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a MedicareAdvantage organization maintains medical records or other health information regarding enrollees under this part, the MedicareAdvantage organization shall establish procedures—

''(1) to safeguard the privacy of any individually identifiable enrollee information;

''(2) to maintain such records and information in a manner that is accurate and timely; and

''(3) to assure timely access of enrollees to such records and information.

''(i) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicareAdvantage organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''(j) RULES REGARDING PROVIDER PARTICIPATION.—

''(1) PROCEDURES.—Insofar as a MedicareAdvantage organization offers benefits under a MedicareAdvantage plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

''(A) providing notice of the rules regarding participation;

''(B) providing written notice of participation decisions that are adverse to physicians; and

''(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

''(2) CONSULTATION IN MEDICAL POLICIES.—A MedicareAdvantage organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

''(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a MedicareAdvantage organization (in relation to an individual enrolled under a MedicareAdvantage plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

''(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicareAdvantage plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicareAdvantage organization offering the plan—

''(i) objects to the provision of such service on moral or religious grounds; and

''(ii) in the manner and through the written instrumentalities such MedicareAdvantage organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

''(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

''(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicareAdvantage plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed pharmacist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social

worker, registered respiratory therapist, and certified respiratory therapy technician.

''(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

''(A) IN GENERAL.—No MedicareAdvantage organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

''(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group; and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a MedicareAdvantage organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

''(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicareAdvantage organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicareAdvantage plan of the organization under this part by the organization's denial of medically necessary care.

''(6) SPECIAL RULES FOR MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a MedicareAdvantage organization (with respect to an individual enrolled in a MedicareAdvantage private fee-for-service plan it offers), if—

''(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

''(B) before providing such services, the provider, professional, or other entity —

''(i) has been informed of the individual's enrollment under the plan; and

''(ii) either—

''(I) has been informed of the terms and conditions of payment for such services under the plan; or

''(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the MedicareAdvantage organization.

''(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicareAdvantage organization described in section 1851(a)(2)(A) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicareAdvantage organization under this part) also applies with respect to an individual so enrolled.

''(2) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—

''(A) BALANCE BILLING LIMITS UNDER MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

''(i) IN GENERAL.—In the case of an individual enrolled in a MedicareAdvantage private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

''(ii) PROCEDURES TO ENFORCE LIMITS.—The MedicareAdvantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out clause (i).

''(iii) ASSURING ENFORCEMENT.—If the MedicareAdvantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

''(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provisions—

''(i) establishing a minimum payment rate in the case of noncontract providers under a MedicareAdvantage private fee-for-service plan, see section 1852(a)(2); or

''(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

''(C) INFORMATION ON BENEFICIARY LIABILITY.—

''(i) IN GENERAL.—Each MedicareAdvantage organization that offers a MedicareAdvantage private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A, B, and D, and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

''(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

''(I) notice of the fact that balance billing is permitted under such subparagraph for such services; and

''(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

''(l) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

''(1) ENSURING RETURN TO HOME SNF.—

''(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a MedicareAdvantage plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

''(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

''(ii) SNF AGREEMENT.—The facility has a contract with the MedicareAdvantage organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the MedicareAdvantage organization for the provision of such services and through which the enrollee would otherwise receive such services.

''(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

''(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the MedicareAdvantage plan.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

''(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a MedicareAdvantage plan.

''(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

''(4) DEFINITIONS.—In this subsection:

''(A) HOME SKILLED NURSING FACILITY.—The term 'home skilled nursing facility' means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a MedicareAdvantage plan, any of the following skilled nursing facilities:

''(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

''(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

''(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

''(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means, with respect to an enrollee in a MedicareAdvantage plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.''.

SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS.

Section 1853 (42 U.S.C. 1395w–23) is amended to read as follows:

''PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

''SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

''(1) MONTHLY PAYMENTS.—

''(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each MedicareAdvantage organization, with respect to coverage of an individual for a month under this part in a MedicareAdvantage payment area, separate monthly payments with respect to—

''(i) benefits under the original medicare fee-for-service program under parts A and B in accordance with subsection (d); and

''(ii) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicareAdvantage organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicareAdvantage plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicareAdvantage payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.

''(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

''(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicareAdvantage organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

''(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

''(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the MedicareAdvantage organization for each individual enrolled with the organization shall equal the MedicareAdvantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

''(i) by multiplying the benchmark amount for that payment area by the ratio of—

''(I) the payment amount determined under subsection (d)(4); to

''(II) the weighted service area benchmark amount determined under subsection (d)(2); and

''(ii) using such risk adjustment factor as specified by the Secretary under subsection (b)(1)(B).

''(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

''(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of payments to plans under subsection (d)(4)(B).

''(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to MedicareAdvantage plans offered by MedicareAdvantage organizations in 2005, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

''(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

''(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicareAdvantage organizations to submit such data and other information as the Secretary deems necessary.

''(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.

''(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each MedicareAdvantage payment area for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the greater of the following amounts (adjusted as appropriate for the application of the risk adjustment methodology under paragraph (3)):

''(A) MINIMUM AMOUNT.—1/12 of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year.

''(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).

''(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'local fee-for-service rate' means the amount of payment for a month in a MedicareAdvantage payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive benefits under the original medicare fee-for-service program option and not enrolled in a MedicareAdvantage plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876.

''(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

''(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

''(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

''(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates are payable during the year—

''(aa) for the indirect costs of medical education under section 1886(d)(5)(B); and

''(bb) for direct graduate medical education costs under section 1886(h).

''(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(b) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

''(1) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(A) The benchmark amount for each MedicareAdvantage payment area (as calculated under subsection (a)(4)) for the year.

''(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each MedicareAdvantage payment area for the year.

''(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

''(A) provide for notice to MedicareAdvantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

''(B) provide such organizations with an opportunity to comment on such proposed changes.

''(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in

methodology used in the announcement in sufficient detail so that MedicareAdvantage organizations can compute each payment factor described in paragraph (1).

''(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

''(1) IN GENERAL.—For purposes of making payments under this part for years before 2006 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area before 2006 or a MedicareAdvantage payment area beginning with such year for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

''(A) BLENDED CAPITATION RATE.—The sum of—

''(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the MedicareAdvantage payment area, as determined under paragraph (3) for the year; and

''(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied by the budget neutrality adjustment factor determined under paragraph (5).

''(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

''(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

''(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

''(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

''(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

''(iv) For 2002 through 2013, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

''(v) For 2014 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(C) MINIMUM PERCENTAGE INCREASE.—

''(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

''(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

''(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

''(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent;

''(B) for 1999, the 'area-specific percentage' is 82 percent and the 'national percentage' is 18 percent;

''(C) for 2000, the 'area-specific percentage' is 74 percent and the 'national percentage' is 26 percent;

''(D) for 2001, the 'area-specific percentage' is 66 percent and the 'national percentage' is 34 percent;

''(E) for 2002, the 'area-specific percentage' is 58 percent and the 'national percentage' is 42 percent; and

''(F) for a year after 2002, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

''(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

''(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

''(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

''(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

''(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

''(I) 1998 is 20 percent;

''(II) 1999 is 40 percent;

''(III) 2000 is 60 percent;

''(IV) 2001 is 80 percent; and

''(V) a succeeding year is 100 percent.

''(C) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

''(I) for the indirect costs of medical education under section 1886(d)(5)(B); and

''(II) for direct graduate medical education costs under section 1886(h).

''(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

''(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

''(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year;

''(ii) the proportion of such rate for the year which is attributable to such type of services; and

''(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

''(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the 'national standardized annual Medicare+Choice capitation rate' for a year is equal to—

''(i) the sum (for all Medicare+Choice payment areas) of the product of—

''(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3); and

''(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

''(ii) the sum of the products described in clause (i)(II) for all areas for that year.

''(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

''(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

''(A) IN GENERAL.—In this part, the 'national per capita Medicare+Choice growth percentage' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

''(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

''(i) for 1998, 0.8 percentage points;

''(ii) for 1999, 0.5 percentage points;

''(iii) for 2000, 0.5 percentage points;

''(iv) for 2001, 0.5 percentage points;

''(v) for 2002, 0.3 percentage points; and

''(vi) for a year after 2002, 0 percentage points.

''(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before

computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

''(7) TRANSITION TO MEDICAREADVANTAGE COMPETITION.—

''(A) IN GENERAL.—For each year (beginning with 2006) payments to MedicareAdvantage plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

''(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2006) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1) for purposes of determining the benchmark amount under subsection (a)(4).

''(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT.—

''(1) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under section 1854(a) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part an are based on the assumptions described in section 1854(a)(2)(A)(iii).

''(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for the benefits under the original medicare fee-for-service program option for each plan equal to the weighted average of the benchmark amounts for benefits under such original medicare fee-for-service program option for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii).

''(3) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the weighted service area benchmark amount (as determined under paragraph (2)) for purposes of determining—

''(A) the payment amount under paragraph (4); and

''(B) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(4) DETERMINATION OF PAYMENT AMOUNT FOR ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the payment amount for MedicareAdvantage plans for the benefits under the original medicare fee-for-service program option as follows:

''(i) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount.

''(ii) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(B) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall adjust the amounts determined under subparagraph (A) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

''(6) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Secretary of the actuarial costs associated with the new benefits.

''(7) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—For purposes of this part, the term 'benefits under the original medicare fee-for-service program option' means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to, or enrolled for, benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.

''(e) MEDICAREADVANTAGE PAYMENT AREA DEFINED.—

''(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'MedicareAdvantage payment area' means a county, or equivalent area specified by the Secretary.

''(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicareAdvantage payment area shall be a State or such other payment area as the Secretary specifies.

''(3) GEOGRAPHIC ADJUSTMENT.—

''(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 2005) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a MedicareAdvantage payment area in the State otherwise determined under paragraph (1)—

''(i) to a single statewide MedicareAdvantage payment area;

''(ii) to the metropolitan based system described in subparagraph (C); or

''(iii) to consolidating into a single MedicareAdvantage payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for MedicareAdvantage payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicareAdvantage payment areas in the State in the absence of the adjustment under this paragraph.

''(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

''(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicareAdvantage payment area; and

''(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicareAdvantage payment area.

''(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

''(f) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

''(1) IN GENERAL.—If the amount of the MedicareAdvantage monthly MSA premium (as defined in section 1854(b)(2)(D)) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicareAdvantage MSA established (and, if applicable, designated) by the individual under paragraph (2).

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

''(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicareAdvantage MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986); and

''(B) if the individual has established more than 1 such MedicareAdvantage MSA, has designated 1 of such accounts as the individual's MedicareAdvantage MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

''(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicareAdvantage MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

''(g) PAYMENTS FROM TRUST FUNDS.—Except as provided in section 1858A(c) (relating to payments for qualified prescription drug coverage), the payment to a MedicareAdvantage organization under this section for individuals enrolled under this part with the organization and payments to a MedicareAdvantage MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October

2006 shall be paid on the first business day of October 2006.

''(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) election under this part of a MedicareAdvantage plan offered by a MedicareAdvantage organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicareAdvantage plan or the original medicare fee-for-service program option (as the case may be) elected before the election with such organization,

''(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge; and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

''(2) termination of election with respect to a MedicareAdvantage organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge;

''(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicareAdvantage organization; and

''(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''(i) SPECIAL RULE FOR HOSPICE CARE.—

''(1) INFORMATION.—A contract under this part shall require the MedicareAdvantage organization to inform each individual enrolled under this part with a MedicareAdvantage plan offered by the organization about the availability of hospice care if—

''(A) a hospice program participating under this title is located within the organization's service area; or

''(B) it is common practice to refer patients to hospice programs outside such service area.

''(2) PAYMENT.—If an individual who is enrolled with a MedicareAdvantage organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

''(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

''(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the MedicareAdvantage organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

''(C) the Secretary shall continue to make monthly payments to the MedicareAdvantage organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).''.

SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

Section 1854 (42 U.S.C. 1395w–24) is amended to read as follows:

''SUBMISSION OF BIDS; PREMIUMS

''SEC. 1854. (a) SUBMISSION OF BIDS BY MEDICAREADVANTAGE ORGANIZATIONS.—

''(1) IN GENERAL.—Not later than the second Monday in September and except as provided in paragraph (3), each MedicareAdvantage organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each MedicareAdvantage plan that the organization intends to offer in a service area in the following year—

''(A) notice of such intent and information on the service area of the plan;

''(B) the plan type for each plan;

''(C) if the MedicareAdvantage plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

''(D) the enrollment capacity (if any) in relation to the plan and each payment area;

''(E) the expected mix, by health status, of enrolled individuals; and

''(F) such other information as the Secretary may specify.

''(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a MedicareAdvantage plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

''(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Information relating to the coverage of benefits under the original medicare fee-for-service program option as follows:

''(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under the original medicare fee-for-service program option to an individual enrolled in the plan that resides in the service area of the plan for a month.

''(ii) For the enhanced medical benefits package offered—

''(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

''(II) the portion of the actuarial value of such benefits package (if any) that will be applied toward satisfying the requirement for additional benefits under subsection (g);

''(III) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (as defined in subsection (b)(2)(C));

''(IV) a description of any cost-sharing;

''(V) a description of whether the amount of the unified deductible has been lowered or the maximum limitations on out-of-pocket expenses have been decreased (relative to the levels used in calculating the plan bid);

''(VI) such other information as the Secretary considers necessary.

''(iii) The assumptions that the MedicareAdvantage organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

''(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—The information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

''(C) DETERMINING PLAN COSTS INCLUDED IN PLAN BID.—For purposes of submitting its plan bid under subparagraph (A)(i) a MedicareAdvantage plan offered by a MedicareAdvantage organization satisfies subparagraphs (A) and (C) of section 1852(a)(1) if the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled in such plan under this part with respect to benefits under the original medicare fee-for-service program option on which that bid is based (ignoring any reduction in cost-sharing offered by such plan as enhanced medical benefits under paragraph (2)(A)(ii) or required under clause (ii) or (iii) of subsection (g)(1)(C)) equals the amount specified in subsection (f)(1)(B).

''(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted.

''(4) REVIEW.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the MedicareAdvantage organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(B) MSA EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3).

''(C) CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—Under the authority under subparagraph (A), the Secretary may disapprove the bid if the Secretary determines that the deductibles, coinsurance, or copayments applicable under the plan discourage access to covered services or are likely to result in favorable selection of MedicareAdvantage eligible individuals.

''(5) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under paragraph (1) for a MedicareAdvantage plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(b) MONTHLY PREMIUMS CHARGED.—

''(1) IN GENERAL.—

''(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization shall be equal to the sum of the following:

''(i) The MedicareAdvantage monthly basic beneficiary premium (if any).

''(ii) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (if any).

''(iii) The MedicareAdvantage monthly obligation for qualified prescription drug coverage (if any).

''(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

''(2) PREMIUM TERMINOLOGY.—For purposes of this part:

''(A) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'MedicareAdvantage monthly basic beneficiary premium' means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (d)(2) for the plan.

''(B) MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term

'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage' means, with respect to a MedicareAdvantage plan, the amount determined under section 1858A(d).

''(C) MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The term 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

''(D) MEDICAREADVANTAGE MONTHLY MSA PREMIUM.—The term 'MedicareAdvantage monthly MSA premium' means, with respect to a MedicareAdvantage plan, the amount of such premium filed under subsection (a)(3) for the plan.

''(c) UNIFORM PREMIUM.—The MedicareAdvantage monthly basic beneficiary premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and the MedicareAdvantage monthly MSA premium charged under subsection (b) of a MedicareAdvantage organization under this part may not vary among individuals enrolled in the plan.

''(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

''(1) BIDS BELOW THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the weighted service area benchmark amount exceeds the plan bid, the Secretary shall require the plan to provide additional benefits in accordance with subsection (g).

''(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be the MedicareAdvantage monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).

''(e) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicareAdvantage organization shall permit the payment of any MedicareAdvantage monthly basic premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits on a monthly basis, may terminate election of individuals for a MedicareAdvantage plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in subsection (g)(1)(C)(i)).

''(f) LIMITATION ON ENROLLEE LIABILITY.—

''(1) FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—The sum of—

''(A) the MedicareAdvantage monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (determined on the same basis as used in determining the plan's bid under paragraph (2)(C)) applicable on average to individuals enrolled under this part with a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A); must equal

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive benefits under the original medicare fee-for-service program option if such individuals were not members of a MedicareAdvantage organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).

''(2) FOR ENHANCED MEDICAL BENEFITS.—If the MedicareAdvantage organization provides to its members enrolled under this part in a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) with respect to enhanced medical benefits relating to benefits under the original medicare fee-for-service program option, the sum of the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year minus the actuarial value of any additional benefits pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C) that the plan specified under subsection (a)(2)(i)(II).

''(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the same geographic area, the State, or in the United States, eligible to enroll in the MedicareAdvantage plan involved under this part or on the basis of other appropriate data.

''(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a MedicareAdvantage private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

''(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1852(a)(1); exceed

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if they were not members of a MedicareAdvantage organization for the year.

''(g) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each MedicareAdvantage organization (in relation to a MedicareAdvantage plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits described in subparagraph (C) as the organization may specify in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (D)).

''(B) EXCESS AMOUNT.—For purposes of this paragraph, the term 'excess amount' means, for an organization for a plan, is 100 percent of the amount (if any) by which the weighted service area benchmark amount (determined under section 1853(d)(2)) exceeds the plan bid (as adjusted under section 1853(d)(1)).

''(C) ADDITIONAL BENEFITS DESCRIBED.—The additional benefits described in this subparagraph are as follows:

''(i) Subject to subparagraph (F), a monthly part B premium reduction for individuals enrolled in the plan.

''(ii) Lowering the amount of the unified deductible and decreasing the maximum limitations on out-of-pocket expenses for individuals enrolled in the plan.

''(iii) A reduction in the actuarial value of plan cost-sharing for plan enrollees.

''(iv) Subject to subparagraph (E), such additional benefits as the organization may specify.

''(v) Contributing to the stabilization fund under paragraph (2).

''(vi) Any combination of the reductions and benefits described in clauses (i) through (v).

''(D) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the term 'adjusted excess amount' means, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

''(E) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

''(F) PREMIUM REDUCTIONS.—

''(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a MedicareAdvantage organization may elect a reduction in its payments under section 1853(a)(1)(A)(i) with respect to a MedicareAdvantage plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

''(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a MedicareAdvantage plan—

''(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

''(II) shall apply uniformly to each enrollee of the MedicareAdvantage plan to which such reduction applies.

''(G) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

''(H) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicareAdvantage organization from providing enhanced medical benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such enhanced medical benefits.

''(2) STABILIZATION FUND.—A MedicareAdvantage organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicareAdvantage plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such Trust Funds.

''(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term 'adjusted community rate' for a service or services means, at the election of a MedicareAdvantage organization, either—

''(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicareAdvantage plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)); or

''(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicareAdvantage coverage, or MedicareAdvantage eligible individuals in the area, in the State, or in the United States, eligible to elect MedicareAdvantage coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine the average amount of payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

''(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments to MedicareAdvantage organizations under section 1853.

''(i) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a MedicareAdvantage organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of 1 or more MedicareAdvantage payment areas.''.

(b) STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Secretary, in consultation with beneficiaries, consumer groups, employers, and Medicare+Choice organizations, shall conduct a study to determine the extent to which the cost-sharing structures under Medicare+Choice plans under part C of title XVIII of the Social Security Act discourage access to covered services or discriminate based on the health status of Medicare+Choice eligible individuals (as defined in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3))).

(2) REPORT.—Not later than December 31, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS.

Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

''SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

''SEC. 1858A. (a) AVAILABILITY.—

''(1) PLANS REQUIRED TO PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE TO ENROLLEES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), on and after January 1, 2006, a MedicareAdvantage organization offering a MedicareAdvantage plan (except for an MSA plan) shall make available qualified prescription drug coverage that meets the requirements for such coverage under this part and part D to each enrollee of the plan.

''(B) PRIVATE FEE-FOR-SERVICE PLANS MAY, BUT ARE NOT REQUIRED TO, PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE.—Pursuant to section 1852(a)(2)(D), a private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

''(2) REFERENCE TO PROVISION PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—For the provisions of part D, made applicable to this part pursuant to paragraph (1), that permit a plan to make available qualified prescription drug coverage that includes coverage of covered drugs that exceeds the coverage required under paragraph (1) of section 1860D–6 in an area, but only if the MedicareAdvantage organization offering the plan also offers a MedicareAdvantage plan in the area that only provides the coverage that is required under such paragraph (1), see paragraph (2) of such section.

''(3) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Pursuant to sections 1854(g)(1)(F) and 1852(a)(3)(D), a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage may not make available coverage of any prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option) to an enrollee as an additional benefit or as an enhanced medical benefit.

''(b) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a MedicareAdvantage organization under a MedicareAdvantage plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, and such other requirements under part D that the Secretary determines appropriate in the same manner as such requirements apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or the plan under this part.

''(c) PAYMENTS FOR PRESCRIPTION DRUGS.—

''(1) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—For each year (beginning with 2006), the Secretary shall pay to each MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(B) APPLICATION OF PART D RISK CORRIDOR, STABILIZATION RESERVE FUND, AND ADMINISTRATIVE EXPENSES PROVISIONS.—The provisions of subsections (b), (c), and (d) of section 1860D–16 shall apply to a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage and payments made to such organization under subparagraph (A) in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan and payments made to such entity under subsection (a) of section 1860D–16.

''(2) PAYMENT FROM PRESCRIPTION DRUG ACCOUNT.—Payment made to MedicareAdvantage organizations under this subsection shall be made from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(d) COMPUTATION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a MedicareAdvantage eligible individual receiving qualified prescription drug coverage under a MedicareAdvantage plan during a year after 2005, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage of such individual in the year shall be determined in the same manner as the monthly beneficiary obligation is determined under section 1860D–17 for eligible beneficiaries enrolled in a Medicare Prescription Drug plan, except that, for purposes of this subparagraph, any reference to the monthly plan premium approved by the Secretary under section 1860D–13 shall be treated as a reference to the monthly premium for qualified prescription drug coverage submitted by the MedicareAdvantage organization offering the plan under section 1854(a)(2)(A) and approved by the Secretary.

''(e) COLLECTION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D–18, including subsection (b) of such section, shall apply to the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage (as determined under subsection (d)) required to be paid by a MedicareAdvantage eligible individual enrolled in a MedicareAdvantage plan in the same manner as such provisions apply to the amount of the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan under part D.

''(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND REINSURANCE PAYMENTS.—For provisions—

''(1) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–19; and

''(2) providing a MedicareAdvantage organization with reinsurance payments for certain expenses incurred in providing qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–20.''.

(b) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(d)(1)(A)(i)''.

SEC. 206. FACILITATING EMPLOYER PARTICIPATION.

Section 1858(h) (as added by section 211) is amended by inserting ''(including subsection (i) of such section)'' after ''section 1857''.

SEC. 207. ADMINISTRATION BY THE CENTER FOR MEDICARE CHOICES.

On and after January 1, 2006, the MedicareAdvantage program under part C of title XVIII of the Social Security Act shall be administered by the Center for Medicare Choices established under section 1808 such title (as added by section 301), and each reference to the Secretary made in such part shall be deemed to be a reference to the Administrator of the Center for Medicare Choices.

SEC. 208. CONFORMING AMENDMENTS.

(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS.—Section 1855 (42 U.S.C. 1395w–25) is amended—

(1) in subsection (b), in the matter preceding paragraph (1), by inserting ''subparagraphs (A), (B), and (D) of'' before ''section 1852(A)(1)''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(b) ESTABLISHMENT OF PSO STANDARDS.—Section 1856 (42 U.S.C. 1395w–26) is amended by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZATIONS.—Section 1857 (42 U.S.C. 1395w–27) is amended—

(1) in subsection (g)(1)—

(A) in subparagraph (B), by striking ''amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums'' and inserting ''amounts of the MedicareAdvantage monthly basic premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits'';

(B) in subparagraph (F), by striking ''or'' after the semicolon at the end;

(C) in subparagraph (G), by adding ''or'' after the semicolon at the end; and

(D) by inserting after subparagraph (G) the following new subparagraph:

''(H)(i) charges any individual an amount in excess of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage under section 1858A(d);

''(ii) provides coverage for prescription drugs that is not qualified prescription drug coverage;

''(iii) offers prescription drug coverage, but does not make standard prescription drug coverage available; or

''(iv) provides coverage for prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option described in section 1851(a)(1)(A)(i)) as an enhanced medical benefit under section 1852(a)(3)(D) or as an additional benefit under section 1854(g)(1)(F),''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(d) DEFINITIONS; MISCELLANEOUS PROVISIONS.—Section 1859 (42 U.S.C. 1395w–28) is amended—

(1) by striking subsection (c) and inserting the following new subsection:

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) ENHANCED MEDICAL BENEFITS.—The term 'enhanced medical benefits' is defined in section 1852(a)(3)(E).

''(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—The term 'MedicareAdvantage eligible individual' is defined in section 1851(a)(3).

''(3) MEDICAREADVANTAGE PAYMENT AREA.—The term 'MedicareAdvantage payment area' is defined in section 1853(d).

''(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The 'national per capita Medicare+Choice growth percentage' is defined in section 1853(c)(6).

''(5) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The terms 'MedicareAdvantage monthly basic beneficiary premium', 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage', and 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' are defined in section 1854(b)(2).

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' has the meaning given such term in section 1860D(9).

''(7) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' has the meaning given such term in section 1860D(10).''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(e) CONFORMING AMENDMENTS EFFECTIVE BEFORE 2006.—

(1) EXTENSION OF MSAS.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended by striking ''January 1, 2003'' and inserting ''January 1, 2004''.

(2) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2)(A), by striking ''THROUGH 2004'' and ''December 31,2004'' and inserting ''THROUGH 2005'' and ''December 31, 2005'', respectively;

(B) in the heading of paragraph (2)(B), by striking ''DURING 2005'' and inserting ''DURING 2006'';

(C) in paragraphs (2)(B)(i) and (2)(C)(i), by striking ''2005'' and inserting ''2006'' each place it appears;

(D) in paragraph (2)(D), by striking ''2004'' and inserting ''2005''; and

(E) in paragraph (4), by striking ''2005'' and inserting ''2006'' each place it appears.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of enactment of this Act.

(e) OTHER CONFORMING AMENDMENTS.—

(1) CONFORMING MEDICARE CROSS-REFERENCES.—

(A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(B) Section 1840(i) (42 U.S.C. 1395s(i)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(C) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(D) Section 1876(k)(3)(A) (42 U.S.C. 1395mm(k)(3)(A)) is amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after section 1853(a).

(F) Section 1876(k)(4) (42 U.S.C. 1395mm(k)(4)(A)) is amended—

(i) in subparagraph (A), by striking ''section 1853(a)(3)(B)'' and inserting ''section 1853(a)(3)(D)''; and

(ii) in subparagraph (B), by striking ''section 1854(g)'' and inserting ''section 1854(h)''.

(G) Section 1876(k)(4)(C) (42 U.S.C. 1395mm(k)(4)(C)) in amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after ''section 1851(e)(6)''.

(H) Section 1894(d) (42 U.S.C. 1395eee(d)) is amended by adding at the end the following new paragraph:

''(3) APPLICATION OF PROVISIONS.—For purposes of paragraphs (1) and (2), the references to section 1853 and subsection (a)(2) of such section in such paragraphs shall be deemed to be references to those provisions as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003.''.

(2) CONFORMING MEDICARE TERMINOLOGY.—Title XVIII (42 U.S.C. 1395 et seq.), except for part C of such title (42 U.S.C. 1395w–21 et seq.), and title XIX (42 U.S.C. 1396 et seq.) are each amended by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

SEC. 209. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 208(d)(3) and subsection (b), the amendments made by this title shall apply with respect to plan years beginning on and after January 1, 2006.

(b) MEDICAREADVANTAGE MSA PLANS.—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if this title had not been enacted.

Subtitle B—Preferred Provider Organizations

SEC. 211. ESTABLISHMENT OF MEDICAREADVANTAGE PREFERRED PROVIDER PROGRAM OPTION.

(a) ESTABLISHMENT OF PREFERRED PROVIDER PROGRAM OPTION.—Section 1851(a)(2) is amended by adding at the end the following new subparagraph:

''(D) PREFERRED PROVIDER ORGANIZATION PLANS.—A MedicareAdvantage preferred provider organization plan under the program established under section 1858.''.

(b) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

''PREFERRED PROVIDER ORGANIZATIONS

''SEC. 1858. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Beginning on January 1, 2006, there is established a preferred provider program under which preferred provider organization plans offered by preferred provider organizations are offered to MedicareAdvantage eligible individuals in preferred provider regions.

''(2) DEFINITIONS.—

''(A) PREFERRED PROVIDER ORGANIZATION.—The term 'preferred provider organization' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to preferred provider organizations.

''(B) PREFERRED PROVIDER ORGANIZATION PLAN.—The term 'preferred provider organization plan' means a MedicareAdvantage plan that—

''(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

''(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

''(iii) is offered by a preferred provider organization.

''(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' means—

''(i) a region established under paragraph (3); and

''(ii) a region that consists of the entire United States.

''(3) PREFERRED PROVIDER REGIONS.—For purposes of this part the Secretary shall establish preferred provider regions as follows:

''(A) There shall be at least 10 regions.

''(B) Each region must include at least 1 State.

''(C) The Secretary may not divide States so that portions of the State are in different regions.

''(D) To the extent possible, the Secretary shall include multistate metropolitan statistical areas in a single region. The Secretary may divide metropolitan statistical areas where it is necessary to establish regions of such size and geography as to maximize the participation of preferred provider organization plans.

''(E) The Secretary may conform the preferred provider regions to the service areas established under section 1860D–10.

''(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to preferred provider organization plans offered by a preferred provider organization.

''(2) SERVICE AREA.—The service area of a preferred provider organization plan shall be a preferred provider region.

''(3) AVAILABILITY.—Each preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

''(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

''(5) ASSURING ACCESS TO SERVICES IN PREFERRED PROVIDER ORGANIZATION PLANS.—

''(A) IN GENERAL.—In addition to any other requirements under this section, in the case of a preferred provider organization plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.

''(B) DETERMINATION OF SUFFICIENT ACCESS.—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

''(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

''(c) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS.—

''(1) PAYMENTS TO ORGANIZATIONS.—

''(A) MONTHLY PAYMENTS.—

''(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsection (e), and section 1859(e)(4), the Secretary shall make, to each preferred provider organization, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

''(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

''(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a preferred provider organization plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

''(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

''(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

''(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

''(2) ANNUAL CALCULATION OF BENCHMARK AMOUNTS FOR PREFERRED PROVIDER REGIONS.—For each year (beginning in 2006), the Secretary shall calculate a benchmark amount for each preferred provider region for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the average of each benchmark amount calculated under section 1853(a)(4) for each MedicareAdvantage payment area for the year within such region, weighted by the number of MedicareAdvantage eligible individuals residing in each such payment area for the year.

''(3) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

''(A) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(i) The benchmark amount for each preferred provider region (as calculated under paragraph (2)(A)) for the year.

''(ii) The factors to be used for adjusting payments described under—

''(I) the comprehensive risk adjustment methodology described in paragraph (1)(C) with respect to each preferred provider region for the year; and

''(II) the methodology used for adjustment for geographic variations within such region established under paragraph (1)(D).

''(B) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall—

''(i) provide for notice to preferred provider organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

''(ii) provide such organizations with an opportunity to comment on such proposed changes.

''(C) EXPLANATION OF ASSUMPTIONS.—In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that preferred provider organizations can compute each payment factor described in such subparagraph.

''(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

''(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The Secretary shall calculate a preferred provider regional benchmark amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

''(i) the payment amount under subparagraph (D); and

''(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(D) DETERMINATION OF PAYMENT AMOUNT.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a preferred provider organization for a preferred provider organization plan as follows:

''(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

''(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in paragraph (3)(A)(ii).

''(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR PREFERRED PROVIDER ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

''(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to preferred provider organizations in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

''(5) PAYMENTS FROM TRUST FUND.—The payment to a preferred provider organization under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

''(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect preferred provider organizations.

''(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to preferred provider organizations.

''(d) SUBMISSION OF BIDS BY PPOs; PREMIUMS.—

''(1) SUBMISSION OF BIDS BY PREFERRED PROVIDER ORGANIZATIONS.—

''(A) IN GENERAL.—For the requirements on submissions by MedicareAdvantage preferred provider organization plans, see section 1854(a)(1).

''(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

''(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the preferred provider organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(E) AUTHORITY TO LIMIT NUMBER OF PLANS IN A REGION.—If there are bids for more than 3 preferred provider organization plans in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

''(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a preferred provider organization plan offered by a preferred provider organization shall be equal to the sum of the following:

''(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

''(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

''(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

''(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

''(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a preferred provider organization to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

''(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For 2007 and 2008, the preferred provider organization offering a preferred provider organization plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

''(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

''(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

''(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a preferred provider organization plan may not exceed an amount determined appropriate by the Administrator.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the preferred provider organization offering the plan.

''(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

''(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

''(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

''(II) 90 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

''(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

''(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

''(ii) 90 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

''(3) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to a range as follows:

''(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 5 percent of such target amount.

''(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 10 percent of such target amount.

''(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

''(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a preferred provider organization plan offered by a preferred provider organization in a year, an amount equal to the sum of—

''(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

''(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

''(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A preferred provider organization that offers a preferred provider organization plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

''(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

''(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a preferred provider organization and a preferred provider organization plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

''(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATIONS.—A preferred provider organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a preferred provider organization plan.

''(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to preferred provider organizations.

''(h) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—The provisions of section 1857 shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.''.

(c) PREFERRED PROVIDER TERMINOLOGY DEFINED.—Section 1859(a) is amended by adding at the end the following new paragraph:

''(3) PREFERRED PROVIDER ORGANIZATION; PREFERRED PROVIDER ORGANIZATION PLAN; PREFERRED PROVIDER REGION.—The terms 'preferred provider organization', 'preferred provider organization plan', and 'preferred provider region' have the meaning given such terms in section 1858(a)(2).''.

Subtitle C—Other Managed Care Reforms

SEC. 221. EXTENSION OF REASONABLE COST CONTRACTS.

(a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended by striking ''2004'' and inserting ''2009''.

(b) APPLICATION OF CERTAIN MEDICARE+CHOICE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Prescription Drug and Medicare Improvements Act of 2003 for plan years beginning on or after January 1, 2004, shall provide that the following provisions of the Medicare+Choice program under part C (and, on and after January 1, 2006, the provisions of the MedicareAdvantage program under such part) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare+Choice organizations and Medicare+Choice plans (or, on and after January 1, 2006, MedicareAdvantage organizations and MedicareAdvantage plans, respectively) under such part:

''(A) Paragraph (1) of section 1852(e) (relating to the requirement of having an ongoing quality assurance program) and paragraph (2)(B) of such section (relating to the required elements for such a program).

''(B) Section 1852(j)(4) (relating to limitations on physician incentive plans).

''(C) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

''(D) Section 1854(g), or, on and after January 1, 2006, section 1854(h) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

''(E) Section 1856(b) (regarding compliance with the standards established by regulation pursuant to such section, including the provisions of paragraph (3) of such section relating to relation to State laws).

''(F) Section 1852(a)(3)(A) (regarding the authority of organizations to include supplemental health care benefits and, on and after January 1, 2006, enhanced medical benefits under the plan subject to the approval of the Secretary).

''(G) The provisions of part C relating to timelines for benefit filings, contract renewal, and beneficiary notification.

''(H) Section 1854(e), or, on and after January 1, 2006, section 1854(f) (relating to proposed cost-sharing under the contract being subject to review by the Secretary).''.

(c) PERMITTING DEDICATED GROUP PRACTICE HEALTH MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE MEDICARE COST CONTRACT PROGRAM.—Section 1876(h)(6) of the Social Security Act (42 U.S.C. 1395mm(h)(6)), as redesignated and amended by subsections (a) and (b), is amended—

(1) in subparagraph (A), by striking ''After the date of the enactment'' and inserting ''Except as provided in subparagraph (C), after the date of the enactment'';

(2) in subparagraph (B), by striking ''subparagraph (C)'' and inserting ''subparagraph (D)'';

(3) by redesignating subparagraph (C) as subparagraph (D); and

(4) by inserting after subparagraph (B), the following new subparagraph:

''(C) Subject to paragraph (5) and subparagraph (D), the Secretary shall approve an application to enter into a reasonable cost contract under this section if—

''(i) the application is submitted to the Secretary by a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act) that, as of January 1, 2004, and except as provided in section 1301(b)(3)(B) of such Act, provides at least 85 percent of the services of a physician which are provided as basic health services through a medical group (or groups), as defined in section 1302(4) of such Act; and

''(ii) the Secretary determines that the organization meets the requirements applicable to such organizations and contracts under this section.''.

SEC. 222. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: ''Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.''.

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–28(b)) is amended by adding at the end the following new paragraph:

''(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

''(i) is institutionalized (as defined by the Secretary);

''(ii) is entitled to medical assistance under a State plan under title XIX; or

''(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.''.

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2008, the plan may restrict the enrollment of individuals under the plan to individuals who are within 1 or more classes of special needs beneficiaries.''.

(d) REPORT TO CONGRESS.—Not later than December 31, 2006, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 1 year after the date of enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 223. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking ''part C or'' and inserting ''part C, with a PACE provider under section 1894 or 1934, or'';

(B) by striking ''(i)'';

(C) by striking ''and (ii)''; and

(D) by striking ''members of the organization'' and inserting ''members of the organization or PACE program eligible individuals enrolled with the PACE provider,''.

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

''(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

''(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

''(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

''(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).''.

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (64), by striking ''and'' at the end;

(B) in paragraph (65), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (65) the following new paragraph:

''(66) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).''.

(2) REFERENCE IN MEDICAID STATUTE.—Section 1934(b) (42 U.S.C. 1396u–4(b)) is amended by adding at the end the following new paragraphs:

''(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

''(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for

noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

''(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

''(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than the date that is 2 months after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the ''Institute'') shall conduct an evaluation of leading health care performance measures and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) catalogue, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance; and

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, health plans, purchasers, and consumers.

(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act, the Institute shall submit to the Secretary of Health and Human Services, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare+Choice program under part C of such title, and any other programs under such title XVIII.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for purposes of conducting the evaluation and preparing the report required by this section.

SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c–3(a)(1)) is amended by inserting '', Medicare+Choice organizations and MedicareAdvantage organizations under part C, and prescription drug card sponsors and eligible entities under part D'' after ''under section 1876''.

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

''(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, prescription drug card sponsors and eligible entities under part D, and Medicare+Choice and MedicareAdvantage plans under part C quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

TITLE III—CENTER FOR MEDICARE CHOICES

SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 111, is amended by inserting after 1806 the following new section:

''ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES

''SEC. 1808. (a) ESTABLISHMENT.—By not later than March 1, 2004, the Secretary shall establish within the Department of Health and Human Services the Center for Medicare Choices, which shall be separate from the Centers for Medicare & Medicaid Services.

''(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Center for Medicare Choices shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall report directly to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Choices, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Center for Medicare Choices. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Center for Medicare Choices as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Center for Medicare Choices as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Center for Medicare Choices who shall be appointed by the Administrator.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be the Acting Administrator of the Center for Medicare Choices during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of MedicareAdvantage plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the

offering of Medicare Prescription Drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including duties relating to—

''(i) reasonable cost contracts with eligible organizations under section 1876(h); and

''(ii) demonstration projects carried out in part or in whole under such parts, including the demonstration project carried out through a MedicareAdvantage (formerly Medicare+Choice) project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) NONINTERFERENCE.—In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may not, to the extent possible, interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs

''(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

''(2) MANAGEMENT STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, such management staff as determined appropriate. Any such manager shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in the following areas:

''(i) The review, negotiation, and administration of health care contracts.

''(ii) The design of health care benefit plans.

''(iii) Actuarial sciences.

''(iv) Compliance with health plan contracts.

''(v) Consumer education and decision making.

''(B) COMPENSATION.—

''(i) IN GENERAL.—Subject to clause (ii), the Administrator shall establish the rate of pay for an individual employed under subparagraph (A).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator of the Center for Medicare Choices, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator of the Center for Medicare Choices as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Center for Medicare Choices.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Center for Medicare Choices, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A, and B, including information on medicare supplemental policies under section 1882.

''(iii) Other areas determined to be appropriate by the Administrator.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, and D, and medicare supplemental policies with benefits under MedicareAdvantage plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the MedicareAdvantage program under part C, and the voluntary prescription drug delivery program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

''(B) DUTIES.—The Medicare Ombudsman shall—

''(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

''(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MedicareAdvantage organization, an eligible entity under part D, or the Secretary; and

''(II) assistance to such beneficiaries with any problems arising from disenrollment from a MedicareAdvantage plan under part C or a prescription drug plan under part D; and

''(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Center for Medicare Choices the Medicare Competitive Policy Advisory Board (in this section referred to as the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) QUALITY.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

''(i) Three members shall be appointed by the President.

''(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

''(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Committee on Finance of the Senate.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) one shall be appointed for a term of 1 year;

''(ii) three shall be appointed for terms of 2 years; and

''(iii) three shall be appointed for terms of 3 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint such additional personnel as the Director considers appropriate.

''(C) ASSISTANCE FROM THE ADMINISTRATOR.—The Administrator shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''By not later than 1 year after the date of the enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER AND CO-SECRETARY OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—The fifth sentence of sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''shall serve as the Secretary'' and inserting ''and the Administrator of the Center for Medicare Choices shall serve as the Co-Secretaries''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2004.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to the succeeding provisions of this clause, for discharges''; and

(2) by adding at the end the following new subclauses:

''(II) For discharges occurring during fiscal year 2004, the operating standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the operating standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

''(III) For discharges occurring in a fiscal year beginning with fiscal year 2005, the Secretary shall compute an operating standardized amount for hospitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking ''each of which is'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2005,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2005,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new clause:

''(iii) for a fiscal year beginning after fiscal year 2004, for hospitals located in all areas, to the product of—

''(I) the applicable operating standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

SEC. 402. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking ''WAGE LEVELS.—The Secretary'' and inserting ''WAGE LEVELS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary''; and

(2) by adding at the end the following new clause:

''(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2004.—

''(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2003, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i).

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.''.

SEC. 403. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

''(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

''(A) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

''(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

''(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

''(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph; and

''(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

''(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term 'low-volume hospital' means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

''(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

''(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

''(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).''.

SEC. 404. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting '', and, after October 1, 2003, for any other hospital described in clause (iv),'' after ''clause (iv)(I)'' in the matter preceding subclause (I).

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xiii)'';

(ii) in subclause (III)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xii)'';

(iii) in subclause (IV)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x) or (xi)'';

(iv) in subclause (V)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xi)''; and

(v) in subclause (VI)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x)'';

(B) in clause (viii), by striking ''The formula'' and inserting ''For discharges occurring before October 1, 2003, the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''With respect to discharges occurring before October 1, 2004, for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

(a) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as follows:

''(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;''.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking ''and the number of beds used at any time for acute care inpatient services does not exceed 15 beds''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2003.

(b) ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) ELIMINATION.—

(A) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2004.

(2) TECHNICAL CORRECTION.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9).

(c) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting ''CERTAIN'' before ''EMERGENCY''; and

(ii) by striking ''PHYSICIANS'' and inserting ''PROVIDERS'';

(B) by striking ''emergency room physicians who are on-call (as defined by the Secretary)'' and inserting ''physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services''; and

(C) by striking ''physicians' services'' and inserting ''services covered under this title''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to costs incurred for services provided on or after January 1, 2004.

(d) AUTHORIZATION OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in subparagraph (C), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (D), by adding ''and'' after the semicolon at the end; and

(C) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for inpatient critical access facility services furnished on or after January 1, 2004.

(e) EXCLUSION OF NEW CAHS FROM PPS HOSPITAL WAGE INDEX CALCULATION.—Section 1886(d)(3)(E)(i) (42 U.S.C. 1395ww(d)(3)(E)(i)), as amended by section 402, is amended by inserting after the first sentence the following new sentence: ''In calculating the hospital wage levels under the preceding sentence applicable with respect to cost reporting periods beginning on or after January 1, 2003, the Secretary shall exclude the wage levels of any facility that became a critical access hospital prior to the cost reporting period for which such hospital wage levels are calculated.''.

(f) PROVISIONS RELATED TO CERTAIN RURAL GRANTS.—

(1) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended—

(A) by redesignating paragraph (3)(F) as paragraph (5) and redesignating and indenting appropriately; and

(B) by inserting after paragraph (3) the following new paragraph:

''(4) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—

''(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible small rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

''(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

''(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

''(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.''.

(2) AUTHORIZATION FOR APPROPRIATIONS.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended to read as follows:

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) HI TRUST FUND.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under—

''(A) subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002; and

''(B) paragraphs (1) and (2) of subsection (g), $40,000,000 in each of the fiscal years 2004 through 2008.

''(2) GENERAL REVENUES.—There are authorized to be appropriated from amounts in the Treasury not otherwise appropriated for making grants to all States under subsection (g)(4), $25,000,000 in each of the fiscal years 2004 through 2008.''.

(3) REQUIREMENT THAT STATES AWARDED GRANTS CONSULT WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE SUCH GRANTS.—

(A) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i–4(g)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

''(6) REQUIRED CONSULTATION FOR STATES AWARDED GRANTS.—A State awarded a grant under paragraph (1) or (2) shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.''.

(B) EFFECTIVE DATE AND APPLICATION.—The amendment made by subparagraph (A) shall take effect on the date of enactment of this Act and shall apply to grants awarded on or after such date and to grants awarded prior to such date to the extent that funds under such grants have not been obligated as of such date.

SEC. 406. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after October 1, 2003.

SEC. 407. SERVICES PROVIDED TO HOSPICE PATIENTS BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS.

(a) IN GENERAL.—Section 1812(d)(2)(A) (42 U.S.C. 1395d(d)(2)(A) in the matter following clause (i)(II), is amended—

(1) by inserting ''or services described in section 1861(s)(2)(K)'' after ''except that clause (i) shall not apply to physicians' services''; and

(2) by inserting '', or by a physician assistant, nurse practitioner, or clinical nurse specialist whom is not an employee of the hospice program, and who the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care,'' after the ''(if not an employee of the hospice program)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to hospice care furnished on or after October 1, 2003.

SEC. 408. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS UNDER MEDICARE.

Effective for cost reporting periods beginning on or after October 1, 2004, for purposes of payments to hospitals under the medicare program under title XVIII of the Social Security Act for costs of approved educational activities (as defined in section 413.85 of title 42 of the Code of Federal Regulations), such approved educational activities shall include professional educational training programs, recognized by the Secretary, for psychologists.

SEC. 409. REVISION OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(B) in clause (ii), by striking ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'' and inserting ''the applicable Federal percentage (specified in subparagraph (E))''; and

(2) by adding at the end the following new subparagraph:

''(E) For purposes of subparagraph (A), for discharges occurring—

''(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

''(ii) on or after October 1, 1997, and before October 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) on or after October 1, 2004, and before October 1, 2009, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent; and

''(iv) on or after October 1, 2009, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent.''.

SEC. 410. AUTHORITY REGARDING GERIATRIC FELLOWSHIPS.

The Secretary shall have the authority to clarify that geriatric training programs are eligible for 2 years of fellowship support for purposes of making payments for direct graduate medical education under subsection (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) and indirect medical education under subsection (d)(5)(B) of such section on or after October 1, 2003.

SEC. 411. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING THE COUNTING OF RESIDENTS IN A NONPROVIDER SETTING AND A TECHNICAL AMENDMENT REGARDING THE 3-YEAR ROLLING AVERAGE AND THE IME RATIO.

(a) CLARIFICATION OF REQUIREMENTS FOR COUNTING RESIDENTS TRAINING IN NONPROVIDER SETTING.—

(1) D-GME.—Section 1886(h)(4)(E) (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.''.

(2) IME.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.''.

(b) LIMITING ONE-YEAR LAG IN THE INDIRECT MEDICAL EDUCATION (IME) RATIO AND THREE-YEAR ROLLING AVERAGE IN RESIDENT COUNT FOR IME AND FOR DIRECT GRADUATE MEDICAL EDUCATION (D-GME) TO MEDICAL RESIDENCY PROGRAMS.—

(1) IME RATIO AND IME ROLLING AVERAGE.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by adding at the end the following new sentence: ''For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, subclauses (I) and (II) shall be applied only with respect to a hospital's approved medical residency training programs in the fields of allopathic and osteopathic medicine.''.

(2) D-GME ROLLING AVERAGE.—Section 1886(h)(4)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(G)) is amended by adding at the end the following new clause:

''(iv) APPLICATION FOR FISCAL YEAR 2004 AND SUBSEQUENT YEARS.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, clauses (i) through (iii) shall be applied only with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine.''.

SEC. 412. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(T) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care—

''(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service,

an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

''(ii) under a program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

SEC. 413. GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(1) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(2) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(b) REPORT.—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

Subtitle B—Provisions Relating to Part B

SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraphs (B) and (C)'' and inserting ''subparagraphs (B), (C), (E), and (F)''; and

(2) by adding at the end the following new subparagraphs:

''(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

''(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

''(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term 'applicable floor index' means—

''(I) 0.980 with respect to services furnished during 2004; and

''(II) 1.000 for services furnished during 2005, 2006, and 2007.

''(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 422. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) PROCEDURES FOR SECRETARY, AND NOT PHYSICIANS, TO DETERMINE WHEN BONUS PAYMENTS UNDER MEDICARE INCENTIVE PAYMENT PROGRAM SHOULD BE MADE.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting ''(1)'' after ''(m)''; and

(2) by adding at the end the following new paragraph:

''(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).''.

(b) EDUCATIONAL PROGRAM REGARDING THE MEDICARE INCENTIVE PAYMENT PROGRAM.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the medicare program on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)).

(c) ONGOING GAO STUDY AND ANNUAL REPORT ON THE MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)). Such study shall focus on whether such program increases the access of medicare beneficiaries who reside in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) as a health professional shortage area to physicians' services under the medicare program.

(2) ANNUAL REPORTS.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Comptroller General considers appropriate.

SEC. 423. INCREASE IN RENAL DIALYSIS COMPOSITE RATE.

Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2005 and 2006, the composite rate for such services shall be increased by 1.6 percent under section 1881(b)(12) of such Act (42 U.S.C. 1395rr(b)(7)), as added by section 433(b)(5).

SEC. 424. EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND TREATMENT OF CERTAIN SOLE COMMUNITY HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPD PPS.

(a) SMALL RURAL HOSPITALS.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by striking ''2004'' and inserting ''2006''.

(b) SOLE COMMUNITY HOSPITALS.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by adding at the end the following:

''(iii) TEMPORARY TREATMENT FOR SOLE COMMUNITY HOSPITALS .—In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished in 2004, 2005, or 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SEC. 425. INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) INCREASE.—

(1) IN GENERAL.—In the case of an applicable covered OPD service (as defined in paragraph (2)) that is furnished by a hospital described in clause (i) or (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)), as amended by section 424, on or after January 1, 2004, and before January 1, 2008, the Secretary shall increase the medicare OPD fee schedule amount (as determined under paragraph (4)(A) of such section) that is applicable for such service in that year (determined without regard to any increase under this section in a previous year) by 5 percent.

(2) APPLICABLE COVERED OPD SERVICES DEFINED.—For purposes of this section, the term ''applicable covered OPD service'' means a covered clinic or emergency room visit that is classified within the groups of covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) established under paragraph (2)(B) of such section.

(b) NO EFFECT ON COPAYMENT AMOUNT.—The Secretary shall compute the copayment amount for applicable covered OPD services under section 1833(t)(8)(A) of the Social Security Act (42 U.S.C. 1395*l*(t)(8)(A)) as if this section had not been enacted.

(c) NO EFFECT ON INCREASE UNDER HOLD HARMLESS OR OUTLIER PROVISIONS.—The Secretary shall apply the temporary hold harmless provision under clause (i) and (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)) and the outlier provision under paragraph (5) of such section as if this section had not been enacted.

(d) WAIVING BUDGET NEUTRALITY AND NO REVISION OR ADJUSTMENTS.—The Secretary shall not make any revision or adjustment under subparagraph (A), (B), or (C) of section 1833(t)(9) of the Social Security Act (42 U.S.C. 1395*l*(t)(9)) because of the application of subsection (a)(1).

(e) NO EFFECT ON PAYMENTS AFTER INCREASE PERIOD ENDS.—The Secretary shall not take into account any payment increase provided under subsection (a)(1) in determining payments for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) under such section that are furnished after January 1, 2008.

(f) TECHNICAL AMENDMENT.—Section 1833(t)(2)(B) (42 U.S.C. 1395*l*(t)(2)(B)) is amended by inserting ''(and periodically revise such groups pursuant to paragraph (9)(A))'' after ''establish groups''.

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2008, for which the transportation originates in a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that

such rates otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent.

''(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.''.

SEC. 427. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

(a) COVERAGE.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 426, is amended by adding at the end the following new paragraph:

''(11) ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES.—

''(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the air ambulance rate if the air ambulance service—

''(i) is medically necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

''(ii) complies with equipment and crew requirements established by the Secretary.

''(B) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if such service is requested—

''(i) by a physician or a hospital in accordance with the physician's or hospital's responsibilities under section 1867 (commonly known as the Emergency Medical Treatment and Active Labor Act);

''(ii) as a result of a protocol established by a State or regional emergency medical service (EMS) agency;

''(iii) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that the patient's condition is such that the time needed to transport the individual by land or the lack of an appropriate ground ambulance, significantly increases the medical risks for the individual; or

''(iv) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist attack.

''(C) AIR AMBULANCE SERVICES DEFINED.—For purposes of this paragraph, the term 'air ambulance service' means fixed wing and rotary wing air ambulance services.''.

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting '', subject to section 1834(l)(11),'' after ''but''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 428. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2004 or 2005 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) NO BENEFICIARY COST-SHARING.—Notwithstanding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 429. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1833(f) (42 U.S.C. 1395*l*(f)) is amended—

(1) in paragraph (1), by striking '', and'' at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking ''in a subsequent year'' and inserting ''in 1989 through 2003''; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

''(3) in 2004, at $80 per visit; and

''(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.''.

SEC. 430. ELIMINATION OF CONSOLIDATED BILLING FOR CERTAIN SERVICES UNDER THE MEDICARE PPS FOR SKILLED NURSING FACILITY SERVICES.

(a) CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (2)(A)(i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii), (iii), and (iv)''; and

(2) by adding at the end of paragraph (2)(A) the following new clause:

''(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

''(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

''(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by a physician or practitioner not affiliated with a rural health clinic or a Federally qualified health center.''.

(b) CERTAIN SERVICES FURNISHED BY AN ENTITY JOINTLY OWNED BY HOSPITALS AND CRITICAL ACCESS HOSPITALS.—For purposes of applying section 411.15(p)–(3)(iii) of title 42 of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned as a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) TECHNICAL AMENDMENTS.—Sections 1842(b)(6)(E) and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E); 1395cc(a)(1)(H)(ii)) are each amended by striking ''section 1888(e)(2)(A)(ii)'' and inserting ''clauses (ii), (iii), and (iv) of section 1888(e)(2)(A)''.

(d) EFFECTIVE DATE.—The amendments made by this section and the provision of subsection (b) shall apply to services furnished on or after January 1, 2004.

SEC. 431. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT AND CERTAIN ORTHOTICS; ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DME PROVIDERS.

(a) FREEZE FOR DME.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (E), by striking ''and'' at the end;

(2) in subparagraph (F)—

(A) by striking ''a subsequent year'' and inserting ''2003''; and

(B) by striking ''the previous year.'' and inserting ''2002;''; and

(3) by adding at the end the following new subparagraphs:

''(G) for each of the years 2004 through 2010—

''(i) in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

''(ii) in the case of covered items not described in clause (i), 0 percentage points; and

''(H) for a subsequent year, the percentage increase described in subparagraph (B) for the year involved.''.

(b) FREEZE FOR OFF-THE-SHELF ORTHOTICS.—Section 1834(h)(4)(A) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)) is amended—

(1) in clause (vii), by striking ''and'' at the end;

(2) in clause (viii), by striking ''a subsequent year'' and inserting ''2003''; and

(3) by adding at the end the following new clauses:

''(ix) for each of the years 2004 through 2010—

''(I) in the case of orthotics that have not been custom-fabricated, 0 percent; and

''(II) in the case of prosthetics, prosthetic devices, and custom-fabricated orthotics, the percentage increase described in clause (viii) for the year involved; and

''(x) for 2011 and each subsequent year, the percentage increase described in clause (viii) for the year involved;''.

(c) ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT PROVIDERS.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(1) by redesignating paragraph (17), as added by section 4551(c)(1) of the Balanced Budget Act of 1997 (111 Stat. 458), as paragraph (19); and

(2) by adding at the end the following new paragraph:

''(20) IDENTIFICATION OF QUALITY STANDARDS.—

''(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for providers of durable medical equipment throughout the United States that are developed by recognized independent accreditation organizations (as designated under subparagraph (B)(i)) and with which such providers shall be required to comply in order to—

''(i) participate in the program under this title;

''(ii) furnish any item or service described in subparagraph (D) for which payment is made under this part; and

''(iii) receive or retain a provider or supplier number used to submit claims for reimbursement for any item or service described in subparagraph (D) for which payment may be made under this title.

''(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—

''(i) IN GENERAL.—Not later that the date that is 6 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall designate independent accreditation organizations for purposes of subparagraph (A).

''(ii) CONSULTATION.—In determining which independent accreditation organizations to designate under clause (i), the Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, suppliers, and manufacturers to review (and advise the Secretary concerning) selection of accrediting organizations and the quality standards of such organizations.

''(C) QUALITY STANDARDS.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

''(D) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection, other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

''(E) PHASED-IN IMPLEMENTATION.—The application of the quality standards described in subparagraph (A) shall be phased-in over a period that does not exceed 3 years.''.

SEC. 432. APPLICATION OF COINSURANCE AND DEDUCTIBLE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) COINSURANCE.—

(1) IN GENERAL.—Section 1833(a) (42 U.S.C. 1395*l*(a)) is amended—

(A) in paragraph (1)(D)(i), by striking ''(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis)''; and

(B) in paragraph (2)(D)(i), by striking ''(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866)''.

(2) CONFORMING AMENDMENT.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A) is amended by striking ''and with respect to clinical diagnostic laboratory tests for which payment is made under part B''.

(b) DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395*l*(b)) is amended—

(1) by striking paragraph (3); and

(2) by redesignating paragraphs (4), (5), and (6) as paragraphs (3), (4), and (5), respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SEC. 433. BASING MEDICARE PAYMENTS FOR COVERED OUTPATIENT DRUGS ON MARKET PRICES.

(a) MEDICARE MARKET BASED PAYMENT AMOUNT.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(1) in paragraph (1), by striking ''equal to 95 percent of the average wholesale price.'' and inserting ''equal to—

''(A) in the case of a drug or biological furnished prior to January 1, 2004, 95 percent of the average wholesale price; and

''(B) in the case of a drug or biological furnished on or after January 1, 2004, the payment amount specified in—

''(i) in the case of such a drug or biological that is first available for payment under this part on or before April 1, 2003, paragraph (4); and

''(ii) in the case of such a drug or biological that is first available for payment under this part after such date, paragraph (5).''; and

(2) by adding at the end the following new paragraphs:

''(4)(A) Subject to subparagraph (C), the payment amount specified in this paragraph for a year for a drug or biological is an amount equal to the lesser of—

''(i) the average wholesale price for the drug or biological; or

''(ii) the amount determined under subparagraph (B)

''(B)(i) Subject to clause (ii), the amount determined under this subparagraph is an amount equal to—

''(I) in the case of a drug or biological furnished in 2004, 85 percent of the average wholesale price for the drug or biological (determined as of April 1, 2003); and

''(II) in the case of a drug or biological furnished in 2005 or a subsequent year, the amount determined under this subparagraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

''(ii) In the case of a vaccine described in subparagraph (A) or (B) of section 1861(s)(10), the amount determined under this subparagraph is an amount equal to the average wholesale price for the drug or biological.

''(C)(i) The Secretary shall establish a process under which the Secretary determines, for such drugs or biologicals as the Secretary determines appropriate, whether the widely available market price to physicians or suppliers for the drug or biological furnished in a year is different from the payment amount established under subparagraph (B) for the year. Such determination shall be based on the information described in clause (ii) as the Secretary determines appropriate.

''(ii) The information described in this clause is the following information:

''(I) Any report on drug or biological market prices by the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States that is made available after December 31, 1999.

''(II) A review of drug or biological market prices by the Secretary, which may include information on such market prices from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physicians, suppliers, or any other source the Secretary determines appropriate.

''(III) Data and information submitted by the manufacturer of the drug or biological or by another entity.

''(IV) Other data and information as determined appropriate by the Secretary.

''(iii) If the Secretary makes a determination under clause (i) with respect to the widely available market price for a drug or biological for a year, the following provisions shall apply:

''(I) Subject to clause (iv), the amount determined under this subparagraph shall be substituted for the amount determined under subparagraph (B) for purposes of applying subparagraph (A)(ii)(I) for the year and all subsequent years.

''(II) The Secretary may make subsequent determinations under clause (i) with respect to the widely available market price for the drug or biological.

''(III) If the Secretary does not make a subsequent determination under clause (i) with respect to the widely available market price for the drug or biological for a year, the amount determined under this subparagraph shall be an amount equal to the amount determined under this subparagraph for the previous year increased by the percentage increase described in subparagraph (B)(i)(II) for the year involved.

''(iv) If the first determination made under clause (i) with respect to the widely available market price for a drug or biological would result in a payment amount in a year that is more than 15 percent less than the amount determined under subparagraph (B) for the drug or biological for the previous year (or, for 2004, the payment amount determined under paragraph (1)(A), determined as of April 1, 2003), the Secretary shall provide for a transition to the amount determined under clause (i) so that the payment amount is reduced in annual increments equal to 15 percent of the payment amount in such previous year until the payment amount is equal to the amount determined under clause (i), as increased each year by the percentage increase described in subparagraph (B)(i)(II) for the year. The preceding sentence shall not apply to a drug or biological where a generic version of the drug or biological first enters the market on or after January 1, 2004 (even if the generic version of the drug or biological is not marketed under the chemical name of such drug or biological).

''(5) In the case of a drug or biological that is first available for payment under this part after April 1, 2003, the following rules shall apply:

''(A) As a condition of obtaining a code to report such new drug or biological and to receive payment under this part, a manufacturer shall provide the Secretary (in a time, manner, and form approved by the Secretary) with data and information on prices at which the manufacturer estimates physicians and suppliers will be able to routinely obtain the drug or biological in the market during the first year that the drug or biological is available for payment under this part and such additional information that the manufacturer determines appropriate.

''(B) During the year that the drug or biological is first available for payment under this part, the manufacturer of the drug or biological shall provide the Secretary (in a time, manner, and form approved by the Secretary) with updated information on the actual market prices paid by such physicians or suppliers for the drug or biological in the year.

''(C) The amount specified in this paragraph for a drug or biological for the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (A) and other information that the Secretary determines appropriate.

''(D) The amount specified in this paragraph for a drug or biological for the year after the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (B) and other information that the Secretary determines appropriate.

''(E) The amount specified in this paragraph for a drug or biological for the year beginning after the year described in subparagraph (D) and each subsequent year is equal to the lesser of—

''(i) the average wholesale price for the drug or biological; or

''(ii) the amount determined—

''(I) by the Secretary under paragraph (4)(C)(i) with respect to the widely available market price for the drug or biological for the year, if such paragraph was applied by substituting 'the payment determined under paragraph (5)(E)(ii)(II) for the year' for 'established under subparagraph (B) for the year'; and

''(II) if no determination described in subclause (I) is made for the drug or biological for the year, under this subparagraph with respect to the drug or biological for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.''.

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR ADMINISTRATION OF DRUGS AND BIOLOGICALS.—

(1) ADJUSTMENT IN PHYSICIAN PRACTICE EXPENSE RELATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking ''The adjustments'' and inserting ''Subject to clause (iv), the adjustments''; and

(ii) by adding at the end the following new clause:

''(iv) EXEMPTION FROM BUDGET NEUTRALITY IN 2004.—Any additional expenditures under this part that are attributable to subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004.''; and

(B) by adding at the end the following new subparagraph:

''(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR DRUG ADMINISTRATION SERVICES FOR 2004.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished in 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

''(i) covers practice expenses for oncology administration services; and

''(ii) meets criteria established by the Secretary for acceptance of such surveys.''.

(2) PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE.—

(A) REVIEW OF POLICY.—The Secretary shall review the policy, as in effect on the date of enactment of this Act, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 anticancer chemotherapeutic agent to an individual on a single day through the push technique.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy if the Secretary determines such modification to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(3) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not disproportionately reduced relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments to such Act made by paragraph (1).

(4) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

''(6)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2004, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled 'Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost' (GAO–03–184), provide for a separate payment for the administration of such blood clotting factors in an amount that the Secretary determines to be appropriate.

''(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2004, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraphs (4) and (5) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

''(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2005 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.''.

(5) INCREASE IN COMPOSITE RATE FOR END STAGE RENAL DISEASE FACILITIES.—Section 1881(b) (42 U.S.C. 1395rr(b) is amended—

(A) in paragraph (7), by adding at the end the following new sentence: ''In the case of dialysis services furnished in 2004 or a subsequent year, the composite rate for such services shall be determined under paragraph (12).''; and

(B) by adding at the end the following new paragraph:

''(12)(A) In the case of dialysis services furnished during 2004, the composite rate for such services shall be the composite rate that would otherwise apply under paragraph (7) for the year increased by an amount to ensure (as estimated by the Secretary) that—

''(i) the sum of the total amount of—

''(I) the composite rate payments for such services for the year, as increased under this paragraph; and

''(II) the payments for drugs and biologicals (other than erythropoetin) furnished in connection with the furnishing of renal dialysis services and separately billed by renal dialysis facilities under paragraphs (4) and (5) of section 1842(o) for the year; is equal to

''(ii) the sum of the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in clause (i)(II) that would have been made if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

''(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased pursuant to section 423 of the Prescription Drug and Medicare Improvement Act of 2003.

''(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent.

''(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 or a subsequent year, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year (determined as if such section 423 had not been enacted), increased by 0.05 percent.

''(E) If the Secretary implements a reduction in the payment amount under paragraph (4)(C) or (5) for a drug or biological described in subparagraph (A)(i)(II) for a year after 2004, the Secretary shall, as estimated by the Secretary—

''(i) increase the composite rate for dialysis services furnished in such year in the same manner that the composite rate for such services for 2004 was increased under subparagraph (A); and

''(ii) increase the percentage increase under subparagraph (C) or (D) (as applicable) for years after the year described in clause (i) to ensure that such increased percentage would result in expenditures equal to the sum of the total composite rate payments for such services for such years and the total payments for drugs and biologicals described in subparagraph (A)(i)(II) is equal to the sum of the total amount of the composite rate payments under this paragraph for such years and the payments for the drugs and biologicals described in subparagraph (A)(i)(II) that would have been made if the reduction in payment amount described in subparagraph had not been made.

''(F) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under this paragraph.''.

(6) HOME INFUSION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraph (4), is amended by adding at the end the following new paragraph:

''(7)(A) Subject to subparagraph (B), in the case of infusion drugs and biologicals furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may make separate payments for furnishing such drugs and biologicals in an amount determined by the Secretary if the Secretary determines such separate payment to be appropriate.

''(B) In determining the amount of any separate payment under subparagraph (A) for a year, the Secretary shall ensure that the total amount of payments under this part for such infusion drugs and biologicals for the year and such separate payments for the year does not exceed the total amount of payments that would have been made under this part for the year for such infusion drugs and biologicals if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.''.

(7) INHALATION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

''(8)(A) Subject to subparagraph (B), in the case of inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may increase payments for such equipment under section 1834(a) and may make separate payments for furnishing such drugs and biologicals if the Secretary determines such increased or separate payments are necessary to appropriately furnish such equipment and drugs and biologicals to beneficiaries.

''(B) The total amount of any increased payments and separate payments under subparagraph (A) for a year may not exceed an amount equal to 10 percent of the amount (as estimated by the Secretary) by which—

''(i) the total amount of payments that would have been made for such drugs and biologicals for the year if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted; exceeds

''(ii) the total amount of payments for such drugs and biologicals under paragraphs (4) and (5).''.

(8) PHARMACY DISPENSING FEE FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1842(o)(2) (42 U.S.C. 1395u(o)(2)) is amended to read as follows:

''(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary—

''(A) in the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, shall

pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy; and

''(B) in the case of a drug or biological not described in subparagraph (A), may pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy.''.

(9) PAYMENT FOR CHEMOTHERAPY DRUGS PURCHASED BUT NOT ADMINISTERED BY PHYSICIANS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) and (7), is amended by adding at the end the following new paragraph:

''(9)(A) Subject to subparagraph (B), the Secretary may increase (in an amount determined appropriate) the amount of payments to physicians for anticancer chemotherapeutic drugs or biologicals that would otherwise be made under this part in order to compensate such physicians for anticancer chemotherapeutic drugs or biologicals that are purchased by physicians with a reasonable intent to administer to an individual enrolled under this part but which cannot be administered to such individual despite the reasonable efforts of the physician.

''(B) The total amount of increased payments made under subparagraph (A) in a year (as estimated by the Secretary) may not exceed an amount equal to 1 percent of the total amount of payments made under paragraphs (4) and (5) for such anticancer chemotherapeutic drugs or biologicals furnished by physicians in such year (as estimated by the Secretary).''.

(c) LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION.—The Secretary shall not implement the revisions in payment amounts for a category of drug or biological as a result of the amendments made by subsection (a) unless the Secretary concurrently implements the adjustments to payment amounts for administration of such category of drug or biological for which the Secretary is required to make an adjustment, as specified in the amendments made by, and provisions of, subsection (b).

(d) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—

(1) DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6), (7), and (9) of subsection (b), is amended by adding at the end the following new paragraph:

''(10) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraph (2) or paragraphs (4) through (9).''.

(2) PHYSICIAN FEE SCHEDULE.—Section 1848(i)(1) (42 U.S.C. 1395w–4(i)(1)) is amended—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(F) adjustments in practice expense relative value units under subsection (c)(2)(H).''.

(3) MULTIPLE CHEMOTHERAPY AGENTS AND OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(e) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON BENEFICIARY ACCESS TO DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study that examines the impact the provisions of, and the amendments made by, this section have on access by medicare beneficiaries to drugs and biologicals covered under the medicare program.

(B) REPORT.—Not later than January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under subparagraph (A) together with such recommendations as the Comptroller General determines to be appropriate.

(2) STUDY AND REPORT BY THE HHS INSPECTOR GENERAL ON MARKET PRICES OF DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct 1 or more studies that—

(i) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers; and

(ii) compare such widely available market prices to the payment amount for such drugs and biologicals under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o).

(B) REQUIREMENT.—In conducting the study under subparagraph (A), the Inspector General shall focus on those drugs and biologicals that represent the largest portions of expenditures under the medicare program for drugs and biologicals.

(C) REPORT.—The Inspector General shall prepare a report on any study conducted under subparagraph (A).

SEC. 434. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended by striking ''and $100 for 1991 and subsequent years'' and inserting the following: '', $100 for 1991 through 2005, $125 for 2006, and for 2007 and thereafter, the amount in effect for the previous year, increase by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar''.

SEC. 435. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: ''(ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if under such arrangement such entity submits the bill for such service and such arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility as described in clause (A)'' and inserting ''except to an employer or entity as described in subparagraph (A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after the date of enactment of this Act.

SEC. 436. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A–551) is amended by inserting '', and for services furnished during 2004 or 2005'' before the period at the end.

SEC. 437. ADEQUATE REIMBURSEMENT FOR OUTPATIENT PHARMACY THERAPY UNDER THE HOSPITAL OUTPATIENT PPS.

(a) SPECIAL RULES FOR DRUGS AND BIOLOGICALS.—Section 1833(t) (42 U.S.C. 1395(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (14); and

(2) by inserting after paragraph (12) the following new paragraph:

''(13) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—

''(A) BEFORE 2007.—

''(i) IN GENERAL.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2005, and before January 1, 2007, hospitals shall be reimbursed as follows:

''(I) DRUGS AND BIOLOGICALS FURNISHED AS PART OF A CURRENT OPD SERVICE.—The amount of payment for a drug or biological described in subparagraph (D) provided as a part of a service that was a covered OPD service on May 1, 2003, shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under section 1842(o) on such date.

''(II) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price that would have been determined under section 1842(o) on May 1, 2003, if payment for such a drug or biological could have been made under this part on that date.

''(ii) UPDATE FOR 2006.—For 2006, the amounts determined under clauses (i) and (ii) shall be the amount established for 2005 increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(B) AFTER 2007.—

''(i) ONGOING STUDY AND REPORTS ON ADEQUATE REIMBURSEMENTS.—

''(I) STUDY.—The Secretary shall contract with an eligible organization (as defined in subclause (IV)) to conduct a study to determine the hospital acquisition and handling costs for each individual drug or biological described in subparagraph (D).

''(II) STUDY REQUIREMENTS.—The study conducted under subclause (I) shall—

''(aa) be accurate to within 3 percent of true mean hospital acquisition and handling costs for each drug and biological at the 95 percent confidence level;

''(bb) begin not later than January 1, 2005; and

''(cc) be updated annually for changes in hospital costs and the addition of newly marketed products.

''(III) REPORTS.—Not later than January 1 of each year (beginning with 2006), the Secretary shall submit to Congress a report on the study conducted under clause (i) together with recommendations for such legislative or administrative action as the Secretary determines to be appropriate.

''(IV) ELIGIBLE ORGANIZATION DEFINED.—In this clause, the term 'eligible organization' means a private, nonprofit organization within the meaning of section 501(c) of the Internal Revenue Code.

''(ii) ESTABLISHMENT OF PAYMENT METHODOLOGY.—Notwithstanding paragraph (6), the Secretary, in establishing a payment methodology on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, shall take into consideration the findings of the study conducted under clause (i)(I) in determining payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007.

''(C) APPLICABLE PERCENTAGE DEFINED.—In this paragraph, the term 'applicable percentage' means—

''(i) with respect to a biological product (approved under a biologics license application under section 351 of the Public Health Service Act), a single source drug (as defined in section 1927(k)(7)(A)(iv)), or an orphan product designated under section 526 of the Food, Drug, and Cosmetic Act to which the prospective payment system established under this subsection did not apply under the final rule for 2003 payments under such system, 94 percent;

''(ii) with respect to an innovator multiple source drug (as defined in section 1927(k)(7)(A)(ii)), 91 percent; and

''(iii) with respect to a noninnovator multiple source drug (as defined in as defined in section 1927(k)(7)(A)(iii)), 71 percent.

''(D) DRUGS AND BIOLOGICALS DESCRIBED.—A drug or biological described in this paragraph is any drug or biological—

''(i) for which the amount of payment was determined under paragraph (6) prior to January 1, 2005;

''(ii) which is assigned to a drug specific ambulatory payment classification on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003; and

''(iii) that would have been reimbursed under paragraph (6) but for the application of this paragraph.''.

(b) EXCEPTIONS TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: ''In determining the budget neutrality adjustment required by the preceding sentence for fiscal years 2005 and 2006, the Secretary shall not take into account any expenditures that would not have been made but for the application of paragraph (13).''.

SEC. 438. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

''(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

''(ii) APPLICATION.—Paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003 unless—

''(I) such application was being made to such drug or biological prior to such date of enactment; and

''(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

''(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequvalent, as determined by the Commissioner of Food and Drugs.

SEC. 439. MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.

(a) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement subsection (a)).

(c) EFFECTIVE DATE.—This section shall apply to clinical trials begun on or after January 1, 2005.

SEC. 440. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: ''No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2002, 2003, 2004, or 2005 and who demonstrates to the Secretary before December 31, 2005, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2005. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2005 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin 1 year after the date of the enactment of this Act and shall end on December 31, 2005.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 441. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term ''chiropractic services'' has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term ''demonstration project'' means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is enrolled under part B of the medicare program.

(4) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a MedicareAdvantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 6 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

(i) 3 shall be in rural areas; and

(ii) 3 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 3 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary

shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

SEC. 442. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

''HEALTH CARE QUALITY DEMONSTRATION PROGRAM

''SEC. 1866C. (a) DEFINITIONS.—In this section:

''(1) BENEFICIARY.—The term 'beneficiary' means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the MedicareAdvantage program) under part C.

''(2) HEALTH CARE GROUP.—

''(A) IN GENERAL.—The term 'health care group' means—

''(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

''(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

''(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

''(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

''(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

''(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

''(1) the provision of incentives to improve the safety of care provided to beneficiaries;

''(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

''(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

''(4) encourage shared decision making between providers and patients;

''(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

''(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

''(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

''(c) ADMINISTRATION BY CONTRACT.—

''(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

''(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

''(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

''(B) streamline documentation and reporting requirements otherwise required under this title.

''(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the traditional fee-for-service program under parts A and B or the package of benefits available through a staff model or a dedicated group model health maintenance organization under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

''(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

''(1) be a health care group;

''(2) meet quality standards established by the Secretary, including—

''(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

''(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

''(C) encouraging patient participation in preference-based decisions;

''(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

''(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

''(3) meet such other requirements as the Secretary may establish.

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

''(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

''(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

''(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

''(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

''(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

''(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

''(i) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.''.

SEC. 443. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section, of which at least 3 shall be in an urban area and at least 1 shall be in a rural area. One of the sites shall be located in the State of Arkansas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) PRINCIPAL CARE PHYSICIAN RESPONSIBILITIES.—The Secretary shall enter into an agreement with each principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall—

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community services organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) COMPLEX CLINICAL CARE MANAGEMENT FEE.—

(1) PAYMENT.—Under an agreement entered into under subsection (c), the Secretary shall pay to each principal care physician, on behalf of each eligible beneficiary under the care of that physician, the complex clinical care management fee developed by the Secretary under paragraph (2).

(2) DEVELOPMENT OF FEE.—The Secretary shall develop a complex care management fee under this paragraph that is paid on a monthly basis and which shall be payment in full for all the functions performed by the principal care physician under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ACTIVITY OF DAILY LIVING.—The term ''activity of daily living'' means eating, toiling, transferring, bathing, dressing, and continence.

(2) CHRONIC CONDITION.—The term ''chronic condition'' means a biological, physical, or mental condition that is likely to last a year or more, for which there is no known cure, for which there is a need for ongoing medical care, and which may affect an individual's ability to carry out activities of daily living or instrumental activities of daily living, or both.

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means any individual who—

(A) is enrolled for benefits under part B of the medicare program;

(B) has at least 4 complex medical conditions (one of which may be cognitive impairment); and

(C) has—

(i) an inability to self-manage their care; or

(ii) a functional limitation defined as an impairment in 1 or more activity of daily living or instrumental activity of daily living.

(4) INSTRUMENTAL ACTIVITY OF DAILY LIVING.—The term ''instrumental activity of daily living'' means meal preparation, shopping, housekeeping, laundry, money management, telephone use, and transportation use.

(5) MEDICARE PROGRAM.—The term ''medicare program'' means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) PRINCIPAL CARE PHYSICIAN.—The term ''principal care physician'' means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 444. MEDICARE FEE-FOR-SERVICE CARE COORDINATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to contract with qualified care management organizations to provide health risk assessment and care management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in rural areas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a care management organization who agrees to furnish care management services to the eligible beneficiary under the demonstration program.

(c) CONTRACTS WITH CMOs.—

(1) IN GENERAL.—The Secretary shall enter into a contract with care management organizations to provide care management services to eligible beneficiaries residing in the area served by the care management organization.

(2) CANCELLATION.—The Secretary may cancel a contract entered into under paragraph (1) if the care management organization does not meet negotiated savings or quality outcomes targets for the year.

(3) NUMBER OF CMOS.—The Secretary may contract with more than 1 care management organization in a geographic area.

(d) PAYMENT TO CMOs.—

(1) PAYMENT.—Under an contract entered into under subsection (c), the Secretary shall pay care management organizations a fee for which the care management organization is partially at risk based on bids submitted by care management organizations.

(2) PORTION OF PAYMENT AT RISK.—The Secretary shall establish a benchmark for quality and cost against which the results of the care management organization are to be measured. The Secretary may not pay a care management organization the portion of the fee described in paragraph (1) that is at risk unless the Secretary determines that the care management organization has met the agreed upon savings and outcomes targets for the year.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(2) WAIVER OF MEDIGAP PREEMPTIONS.—The Secretary shall waive any provision of section 1882 of the Social Security Act that would prevent an insurance carrier described in subsection (h)(3)(D) from participating in the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) CARE MANAGEMENT SERVICES.—The term ''care management services'' means services that are furnished to an eligible beneficiary (as defined in paragraph (2)) by a care management organization (as defined in paragraph (3)) in accordance with guidelines established by the Secretary that are consistent with guidelines established by the American Geriatrics Society.

(2) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) at high-risk (as defined by the Secretary, but including eligible beneficiaries with multiple sclerosis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).

(3) CARE MANAGEMENT ORGANIZATION.—The term ''care management organization'' means an organization that meets such qualifications as the Secretary may specify and includes any of the following:

(A) A physician group practice, hospital, home health agency, or hospice program.

(B) A disease management organization.

(C) A Medicare+Choice or MedicareAdvantage organization.

(D) Insurance carriers offering medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(E) Such other entity as the Secretary determines to be appropriate.

SEC. 445. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component;

(4) an evaluation of whether there is a sound economic basis for the implementation of the adjustment under subparagraphs (E) and (F) of section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)), as added by section 421, in those areas in which the adjustment applies;

(5) an evaluation of the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(A) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(B) the mobility of physicians, including specialists, over the last decade; and

(6) an evaluation of appropriateness of extending such adjustment or making such adjustment permanent.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

Subtitle C—Provisions Relating to Parts A and B

SEC. 451. INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after October 1, 2003, and before October 1, 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 452. LIMITATION ON REDUCTION IN AREA WAGE ADJUSTMENT FACTORS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

Section 1895(b)(4)(C) (42 U.S.C. 1395fff(b)(4)(C)) is amended—

(1) by striking ''FACTORS.—The Secretary'' and inserting ''FACTORS.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary''; and

(2) by adding at the end the following new clause:

''(ii) LIMITATION ON REDUCTION IN FISCAL YEAR 2005 AND 2006.—For fiscal years 2004, 2005, and 2006, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more that 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.''.

SEC. 453. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITS ON PHYSICIAN REFERRALS.—

(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(A) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(i) by striking ''and'' at the end of subparagraph (A); and

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

''(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and''.

(B) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

''(7) SPECIALTY HOSPITAL.—

''(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

''(i) patients with a cardiac condition;

''(ii) patients with an orthopedic condition;

''(iii) patients receiving a surgical procedure; or

''(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

''(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

''(i) determined by the Secretary—

''(I) to be in operation before June 12, 2003; or

''(II) under development as of such date;

''(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

''(iii) that meets such other requirements as the Secretary may specify.''.

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

''(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

''(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

''(B) the entity is not a specialty hospital (as defined in subsection (h)(7)); and

''(C) the Secretary determines, with respect to such entity, that such services would not be available in such area but for the ownership or investment interest.''.

(b) EFFECTIVE DATE.—Subject to paragraph (2), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

SEC. 454. DEMONSTRATION PROGRAM FOR SUBSTITUTE ADULT DAY SERVICES.

(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which the Secretary provides eligible medicare beneficiaries with coverage under the medicare program of substitute adult day services furnished by an adult day services facility.

(b) PAYMENT RATE FOR SUBSTITUTE ADULT DAY SERVICES.—

(1) PAYMENT RATE.—For purposes of making payments to an adult day services facility for substitute adult day services under the demonstration program, the following rules shall apply:

(A) ESTIMATION OF PAYMENT AMOUNT.—The Secretary shall estimate the amount that would otherwise be payable to a home health agency under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for all home health services described in subsection (i)(4)(B)(i) under the plan of care.

(B) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the total amount payable for substitute adult day services under the plan of care is equal to 95 percent of the amount estimated to be payable under subparagraph (A).

(2) LIMITATION ON BALANCE BILLING.—Under the demonstration program, an adult day services facility shall accept as payment in full for substitute adult day services (including those services described in clauses (ii) through (iv) of subsection (i)(4)(B)) furnished

by the facility to an eligible medicare beneficiary the amount of payment provided under the demonstration program for home health services consisting of substitute adult services.

(3) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration program and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration program and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration program had not been conducted, the Secretary shall adjust the rate of payment to adult day services facilities under paragraph (1)(B) in order to eliminate such excess.

(c) DEMONSTRATION PROGRAM SITES.—The demonstration program shall be conducted in not more than 3 sites selected by the Secretary.

(d) DURATION; IMPLEMENTATION.—

(1) DURATION.—The Secretary shall conduct the demonstration program for a period of 3 years.

(2) IMPLEMENTATION.—The Secretary may not implement the demonstration program before October 1, 2004.

(e) VOLUNTARY PARTICIPATION.—Participation of eligible medicare beneficiaries in the demonstration program shall be voluntary.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration program.

(2) MAY NOT WAIVE ELIGIBILITY REQUIREMENTS FOR HOME HEALTH SERVICES.—The Secretary may not waive the beneficiary eligibility requirements for home health services under title XVIII of the Social Security Act.

(g) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration program.

(2) REPORT.—Not later than 30 months after the commencement of the demonstration program, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the eligible medicare beneficiaries participating in the demonstration program as compared to such outcomes and costs to such beneficiaries receiving only home health services under title XVIII of the Social Security Act for the same health conditions.

(B) Such recommendations regarding the extension, expansion, or termination of the program as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) ADULT DAY SERVICES FACILITY.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the term ''adult day services facility'' means a public agency or private organization, or a subdivision of such an agency or organization, that—

(i) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(ii) provides the items and services described in paragraph (4)(B); and

(iii) meets the requirements of paragraphs (2) through (8) of subsection (o).

(B) INCLUSION.—Notwithstanding subparagraph (A), the term ''adult day services facility'' shall include a home health agency in which the items and services described in clauses (ii) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) WAIVER OF SURETY BOND.—The Secretary may waive the requirement of a surety bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(2) ELIGIBLE MEDICARE BENEFICIARY.—The term ''eligible medicare beneficiary'' means an individual eligible for home health services under title XVIII of the Social Security Act.

(3) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) SUBSTITUTE ADULT DAY SERVICES.—

(A) IN GENERAL.—The term ''substitute adult day services'' means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services:

(i) Items and services described in paragraphs (1) through (7) of such section 1861(m).

(ii) Meals.

(iii) A program of supervised activities designed to promote physical and mental health and furnished to the individual by the adult day services facility in a group setting for a period of not fewer than 4 and not greater than 12 hours per day.

(iv) A medication management program (as defined in subparagraph (C)).

(C) MEDICATION MANAGEMENT PROGRAM.—For purposes of subparagraph (B)(iv), the term ''medication management program'' means a program of services, including medicine screening and patient and health care provider education programs, that provides services to minimize—

(i) unnecessary or inappropriate use of prescription drugs; and

(ii) adverse events due to unintended prescription drug-to-drug interactions.

SEC. 455. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION OF AN INTERIM FINAL REGULATION.

(a) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) With respect to the publication of a final regulation based on the previous publication of an interim final regulation—

''(i) subject to subparagraph (B), the Secretary shall publish the final regulation within the 12-month period that begins on the date of publication of the interim final regulation;

''(ii) if a final regulation is not published by the deadline established under this paragraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and

''(iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

''(B) If the Secretary determines before the deadline otherwise established in this paragraph that there is good cause, specified in a notice published before such deadline, for delaying the deadline otherwise applicable under this paragraph, the deadline otherwise established under this paragraph shall be extended for such period (not to exceed 12 months) as the Secretary specifies in such notice.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to interim final regulations published on or after such date.

(c) STATUS OF PENDING INTERIM FINAL REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

''(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

''(C)(i) Except as provided in clause (ii), a substantive change may not take effect before the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of enactment of this Act.

SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a)(1), is amended by adding at the end the following new subsection:

''(e)(1) Not later than 2 years after the date of enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of all communications and correspondence.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

Subtitle B—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges, including ensuring that such judges are in an office that is functionally and operationally separate from the Centers for Medicare & Medicaid Services and the Center for Medicare Choices.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff).

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress, the Commissioner of Social Security, and the Secretary a report on such evaluation.

(c) SUBMISSION OF GAO REPORT REQUIRED BEFORE PLAN IMPLEMENTATION.—The Commissioner of Social Security and the Secretary may not implement the plan developed under subsection (a) before the date that is 6 months after the date the report required under subsection (b)(2) is submitted to the Commissioner and the Secretary.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision''; and

(2) by adding at the end the following new paragraph:

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review entity—

''(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than 1 applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

''(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, a 'review entity' is a panel of no more than 3 members from the Departmental Appeals Board, selected for the purpose of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

(2) by adding at the end the following new subparagraph:

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) GAO STUDY AND REPORT ON ACCESS TO JUDICIAL REVIEW.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the access of medicare beneficiaries and health care providers to judicial review of actions of the Secretary and the Department of Health and Human Services with respect to items and services under title XVIII of the Social Security Act subsequent to February 29, 2000, the date of the decision of Shalala, Secretary of Health and Human Services, et al. v. Illinois Council on Long Term Care, Inc. (529 U.S. 1 (2000)).

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations as the Comptroller General determines to be appropriate.

(d) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

''(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 514. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

''(3) TIMELY COMPLETION OF THE RECORD.—

''(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

''(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

''(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

''(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

''(i) written or testimonial evidence, or both, submitted by the person filing the request,

''(ii) written or oral argument, or both,

''(iii) the decision of, and the record for, the prior level of appeal, and

''(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.''.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

''(A) the reasons for the determination, including, as appropriate—

''(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

''(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

''(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

''(i) to the extent appropriate, a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

''(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

''(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical or scientific rationale for the decision.''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

(B) by adding at the end the following new paragraph:

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking ''such information as is required for an appeal'' and inserting ''the record for the appeal''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting ''(except in the case of a utilization and quality control peer review organization, as defined in section 1152)'' after ''means an entity or organization that''; and

(ii) by striking the period at the end and inserting the following: ''and meets the following requirements:

''(A) GENERAL REQUIREMENTS.—

''(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

''(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

''(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''; and

(B) in paragraph (3)(A), by striking '', and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS OF REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

(B) by adding at the end the following new subsection:

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) a nonaffiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''12'' and inserting ''4''.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

''(d) EFFECTIVE DATE.—

''(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2004.

''(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003:

''(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

''(B) Subsection (c)(3)(C)(iii) of such section.

''(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

''(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.''.

(2) CONFORMING AMENDMENTS.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 515. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

''(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

''(2) providers of services, physicians, practitioners, and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied are provided a mechanism to appeal such denial and a deadline for consideration of such appeals.''.

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 502 and 503, is amended by adding at the end the following new subsection:

''(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.''.

SEC. 516. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

''(5) AGGRIEVED PARTY DEFINED.—In this section, the term 'aggrieved party' means—

''(A) with respect to a national coverage determination, an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; and

''(B) with respect to a local coverage determination—

''(i) an individual who is entitled to benefits under part A, or enrolled under part B, or both, who is adversely affected by such a determination; or

''(ii) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.''.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting '', including, where appropriate, the specific requirements and clinical indications relating to the medical necessity of an item or service'' before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 514(d)(2)(B), is amended by adding at the end the following new subsection:

''(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

''(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

''(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

''(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

''(B) each reversal described in subparagraph (A) involves substantially similar material facts;

''(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

''(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

''(4) APPROVAL OR REJECTION OF REQUEST.—

''(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

''(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.''.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after October 1, 2003;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and beneficiary services functions as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 6 years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

''(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

''(B) CONSIDERATIONS.—The Secretary shall include, as 1 of the standards, provider and beneficiary satisfaction levels.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(6) RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.—A contract with a medicare administrative contractor under this section to perform the function of developing local coverage determinations (as defined in section 1869(f)(2)(B)) shall provide that the contractor shall—

''(A) designate at least 1 different individual to serve as medical director for each State for which such contract performs such function;

''(B) utilize such medical director in the performance of such function; and

''(C) appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in, the development of a local coverage determination in an advisory capacity.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ''False Claims Act'').

''(5) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,'';

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor'';

(E) in paragraph (5), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier'' and ''carrier responses'' and inserting ''contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor'' and ''contractor responses'', respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative

contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

''(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

''(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

''(2) GAO REVIEW OF METHODOLOGY.—The Comptroller General of the United States shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

''(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.''.

(2) REPORT.—The Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of the Social Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)'';

(B) in subparagraph (B), by striking ''The amount appropriated'' and inserting ''Subject to subparagraph (C), the amount appropriated''; and

(C) by adding at the end the following new subparagraph:

''(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

''(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

''(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.''.

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

''(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

''(c) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

''(d) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

''(1) of the screens used for identifying claims that will be subject to medical review; or

''(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

''(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

''(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall consider the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

''(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2004.

SEC. 533. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 502(a), is amended by adding at the end the following new paragraph:

''(2) If—

''(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

''(i) by the Secretary; or

''(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

''(B) the Secretary determines that—

''(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

''(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

''(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of enactment of this Act.

SEC. 534. MEDICARE PROVIDER OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

''(b) MEDICARE PROVIDER OMBUDSMAN.—

''(1) IN GENERAL.—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

''(2) DUTIES.—The Medicare Provider Ombudsman shall—

''(A) provide assistance, on a confidential basis, to entities and individuals providing items and services, including covered drugs under part D, under this title with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(i) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

''(3) STAFF.—The Secretary shall provide the Medicare Provider Ombudsman with appropriate staff.''.

(b) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account)) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (42 U.S.C. 1395ee) (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAMS.

(a) DEMONSTRATION ON THE PROVISION OF ADVICE AND ASSISTANCE TO MEDICARE BENEFICIARIES AT LOCAL OFFICES OF THE SOCIAL SECURITY ADMINISTRATION.—

(1) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this subsection referred to as the ''demonstration program'') under which medicare specialists

employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(2) LOCATIONS.—

(A) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) DURATION.—The demonstration program shall be conducted over a 3-year period.

(4) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(b) DEMONSTRATION ON PROVIDING PRIOR DETERMINATIONS.—

(1) ESTABLISHMENT.—By not later than 1 year after the date of enactment of this Act, the Secretary shall establish a demonstration project to test the administrative feasibility of providing a process for medicare beneficiaries and entities and individuals furnishing such beneficiaries with items and services under title XVIII of the Social Security Act program to make a request for, and receive, a determination (after an advance beneficiary notice is issued with respect to the item or service involved but before such item or service is furnished to the beneficiary) as to whether the item or service is covered under such title consistent with the applicable requirements of section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A)) (relating to medical necessity).

(2) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program conducted under paragraph (1).

(B) REPORT.—By not later than January 1, 2006, the Secretary shall submit to Congress a report on such evaluation together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

''(g) CONDUCT OF PREPAYMENT REVIEW.—

''(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

''(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

''(h) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

''(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

''(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

''(B) PAYMENT OF INTEREST.—

''(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

''(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

''(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

''(3) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a

medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

''(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

''(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

''(6) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

''(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of over-utilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

TITLE VI—OTHER PROVISIONS

SEC. 601. INCREASE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)) is amended—

(1) in the paragraph heading, by striking ''FISCAL YEARS 2001 AND 2002'' and inserting ''CERTAIN FISCAL YEARS'';

(2) in subparagraph (A)—

(A) in clause (i)—

(i) by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

(ii) by striking ''and'' at the end;

(B) in clause (ii), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(iii) for fiscal year 2004, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

''(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003; and

''(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2004; and

''(iv) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

''(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002, 2003, and 2004; and

''(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2005.''; and

(3) in subparagraph (C)—

(A) in the subparagraph heading, by striking ''AFTER FISCAL YEAR 2002'' and inserting ''FOR OTHER FISCAL YEARS''; and

(B) by striking ''2003 or'' and inserting ''2003, fiscal year 2006, or''.

(b) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)), as amended by paragraph (1), is amended—

(1) in subparagraph (A), by inserting ''and except as provided in subparagraph (C)'' after ''paragraph (2)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following:

''(C) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

''(i) IN GENERAL.—Notwithstanding subparagraph (A), the DSH allotment for the District of Columbia for fiscal year 2004, shall be determined by substituting ''49'' for ''32'' in the item in the table contained in paragraph (2) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such

allotment, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2000, 2001, 2002, and 2003.

''(ii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2004.—The DSH allotment for the District of Columbia for fiscal year 2003, fiscal year 2005, or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotment determined under clause (i).''.

(c) CONFORMING AMENDMENT.—Section 1923(f)(3) of such Act (42 U.S.C. 1396r–4(f)(3)) is amended by inserting '', paragraph (4),'' after ''subparagraph (B)''.

SEC. 602. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE UNDER THE MEDICAID PROGRAM FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking ''In the case of'' and inserting the following:

''(A) IN GENERAL.—In the case of''; and

(2) by adding at the end the following:

''(B) INCREASE IN FLOOR FOR FISCAL YEARS 2004 AND 2005.—

''(i) FISCAL YEAR 2004.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year.

''(ii) FISCAL YEAR 2005.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2001, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2004, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2004.

''(iii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2005.—The DSH allotment for any State for fiscal year 2006 or any succeeding fiscal year shall be determined under this subsection without regard to the DSH allotments determined under this subparagraph.''.

(b) ALLOTMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following:

''(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 that was implemented on January 1, 1994, is revoked or terminated before the end of either such fiscal year, the Secretary shall—

''(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

''(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that provides for the maximum amount (permitted consistent with paragraph (3)(B)(ii)) that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.''.

(2) TREATMENT OF INSTITUTIONS FOR MENTAL DISEASES.—Section 1923(h)(1) of the Social Security Act (42 U.S.C. 1396r–4(h)(1)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''(subject to paragraph (3))'' after ''the lesser of the following''; and

(B) by adding at the end the following new paragraph:

''(3) SPECIAL RULE.—The limitation of paragraph (1) shall not apply in the case of a State to which subsection (f)(6) applies.''.

SEC. 603. INCREASED REPORTING REQUIREMENTS TO ENSURE THE APPROPRIATENESS OF PAYMENT ADJUSTMENTS TO DISPROPORTIONATE SHARE HOSPITALS UNDER THE MEDICAID PROGRAM.

Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(j) ANNUAL REPORTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to submit an annual report that—

''(1) identifies each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year; and

''(2) includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.''.

SEC. 604. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: ''(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)''.

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

''(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

(2) by adding at the end the following new paragraph:

''(4)(A) With respect to any or all of fiscal years 2005 through 2007, a State may elect (in a plan amendment under this title) to provide medical assistance under this title (including under a waiver authorized by the Secretary) for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

''(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

''(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).''.

(b) SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

''(C) Section 1903(v)(4) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX and only with respect to any or all of fiscal years 2005 through 2007.''.

SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(i) CONSUMER OMBUDSMAN ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Consumer Ombudsman Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO ACCOUNT FOR HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.—

''(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year beginning with fiscal year 2005, the amount described in subparagraph (B) for such fiscal year for the purpose of making grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

''(B) AMOUNT DESCRIBED.—For purposes of subparagraph (A), the amount described in this subparagraph for a fiscal year is the amount equal to the product of—

''(i) $1; and

''(ii) the total number of individuals receiving benefits under this title for the calendar year ending on December 31 of the preceding fiscal year.''.

(b) CONFORMING AMENDMENT.—Section 4360(g) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–4(g)) is amended to read as follows:

''(g) FUNDING.—The Secretary shall use amounts appropriated to the Consumer Ombudsman Account in accordance with section 1817(i) of the Social Security Act for a fiscal year for making grants under this section for that fiscal year.''.

SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR LOW-INCOME BENEFICIARIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered drugs for an individual described in subsection (b) differs from the drug utilization and access to covered drugs of an individual who qualifies for the transitional assistance prescription drug card program under section 1807A of the Social Security Act (as added by section 111) or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act (as added by section 101).

(b) INDIVIDUAL DESCRIBED.—An individual is described in this subsection if the individual does not qualify for the transitional assistance prescription drug card program under section 1807A of the Social Security Act or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act solely as a result of the application of an assets test to the individual.

(c) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(d) DEFINITIONS.—In this section:

(1) COVERED DRUGS.—The term ''covered drugs'' has the meaning given that term in section 1860D(a)(D) of the Social Security Act.

(2) QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARY; QUALIFYING INDIVIDUAL.—The terms ''qualified medicare beneficiary'', ''specified low-income medicare beneficiary'' and ''qualifying individual'' have the meaning given those terms under section 1860D–19 of the Social Security Act.

SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.

At the end of the Social Security Act, add the following new title:

''TITLE XXII—HEALTH CARE INFRASTRUCTURE IMPROVEMENT

''SEC. 2201. DEFINITIONS.

''In this title, the following definitions apply:

''(1) ELIGIBLE PROJECT COSTS.—The term 'eligible project costs' means amounts substantially all of which are paid by, or for the account of, an obligor in connection with a project, including the cost of—

''(A) development phase activities, including planning, feasibility analysis, revenue forecasting, environmental study and review, permitting, architectural engineering and design work, and other preconstruction activities;

''(B) construction, reconstruction, rehabilitation, replacement, and acquisition of facilities and real property (including land related to the project and improvements to land), environmental mitigation, construction contingencies, and acquisition of equipment;

''(C) capitalized interest necessary to meet market requirements, reasonably required reserve funds, capital issuance expenses, and other carrying costs during construction;

''(D) major medical equipment determined to be appropriate by the Secretary; and

''(E) refinancing projects or activities that are otherwise eligible for financial assistance under subparagraphs (A) through (D).

''(2) FEDERAL CREDIT INSTRUMENT.—The term 'Federal credit instrument' means a secured loan, loan guarantee, or line of credit authorized to be made available under this title with respect to a project.

''(3) INVESTMENT-GRADE RATING.—The term 'investment-grade rating' means a rating category of BBB minus, Baa3, or higher assigned by a rating agency to project obligations offered into the capital markets.

''(4) LENDER.—The term 'lender' means any non-Federal qualified institutional buyer (as defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known as Rule 144A(a) of the Securities and Exchange Commission and issued under the Securities Act of 1933 (15 U.S.C. 77a et seq.)), including—

''(A) a qualified retirement plan (as defined in section 4974(c) of the Internal Revenue Code of 1986) that is a qualified institutional buyer; and

''(B) a governmental plan (as defined in section 414(d) of the Internal Revenue Code of 1986) that is a qualified institutional buyer.

''(5) LINE OF CREDIT.—The term 'line of credit' means an agreement entered into by the Secretary with an obligor under section 2204 to provide a direct loan at a future date upon the occurrence of certain events.

''(6) LOAN GUARANTEE.—The term 'loan guarantee' means any guarantee or other pledge by the Secretary to pay all or part of the principal of and interest on a loan or other debt obligation issued by an obligor and funded by a lender.

''(7) LOCAL SERVICER.—The term 'local servicer' means a State or local government or any agency of a State or local government that is responsible for servicing a Federal credit instrument on behalf of the Secretary.

''(8) OBLIGOR.—The term 'obligor' means a party primarily liable for payment of the principal of or interest on a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

''(9) PROJECT.—The term 'project' means any project that is designed to improve the health care infrastructure, including the construction, renovation, or other capital improvement of any hospital, medical research facility, or other medical facility or the purchase of any equipment to be used in a hospital, research facility, or other medical research facility.

''(10) PROJECT OBLIGATION.—The term 'project obligation' means any note, bond, debenture, lease, installment sale agreement, or other debt obligation issued or entered into by an obligor in connection with the financing of a project, other than a Federal credit instrument.

''(11) RATING AGENCY.—The term 'rating agency' means a bond rating agency identified by the Securities and Exchange Commission as a Nationally Recognized Statistical Rating Organization.

''(12) SECURED LOAN.—The term 'secured loan' means a direct loan or other debt obligation issued by an obligor and funded by the Secretary in connection with the financing of a project under section 2203.

''(13) STATE.—The term 'State' has the meaning given the term in section 101 of title 23, United States Code.

''(14) SUBSIDY AMOUNT.—The term 'subsidy amount' means the amount of budget authority sufficient to cover the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a net present value basis, excluding administrative costs and any incidental effects on governmental receipts or outlays in accordance with the provisions of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.).

''(15) SUBSTANTIAL COMPLETION.—The term 'substantial completion' means the opening of a project to patients or for research purposes.

''SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT SELECTION.

''(a) ELIGIBILITY.—To be eligible to receive financial assistance under this title, a project shall meet the following criteria:

''(1) APPLICATION.—A State, a local servicer identified under section 2205(a), or the entity undertaking a project shall submit a project application to the Secretary.

''(2) ELIGIBLE PROJECT COSTS.—To be eligible for assistance under this title, a project shall have total eligible project costs that are reasonably anticipated to equal or exceed $40,000,000.

''(3) SOURCES OF REPAYMENTS.—Project financing shall be repayable, in whole or in part, from reliable revenue sources as described in the application submitted under paragraph (1).

''(4) PUBLIC SPONSORSHIP OF PRIVATE ENTITIES.—In the case of a project that is undertaken by an entity that is not a State or local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be publicly sponsored or sponsored by an entity that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code.

''(b) SELECTION AMONG ELIGIBLE PROJECTS.—

''(1) ESTABLISHMENT.—The Secretary shall establish criteria for selecting among projects that meet the eligibility criteria specified in subsection (a).

''(2) SELECTION CRITERIA.—

''(A) IN GENERAL.—The selection criteria shall include the following:

''(i) The extent to which the project is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

''(ii) The creditworthiness of the project, including a determination by the Secretary that any financing for the project has appropriate security features, such as a rate covenant, credit enhancement requirements, or debt services coverages, to ensure repayment.

''(iii) The extent to which assistance under this title would foster innovative public-private partnerships and attract private debt or equity investment.

''(iv) The likelihood that assistance under this title would enable the project to proceed at an earlier date than the project would otherwise be able to proceed.

''(v) The extent to which the project uses or results in new technologies.

''(vi) The amount of budget authority required to fund the Federal credit instrument made available under this title.

''(vii) The extent to which the project helps maintain or protect the environment.

''(B) SPECIFIC REQUIREMENTS.—The selection criteria shall require that a project applicant—

''(i) be engaged in research in the causes, prevention, and treatment of cancer;

''(ii) be designated as a cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State; and

''(iii) be located in a State that, on the date of enactment of this title, has a population of less than 3,000,000 individuals.

''(C) RATING LETTER.—For purposes of subparagraph (A)(ii), the Secretary shall require each project applicant to provide a rating letter from at least 1 rating agency indicating that the project's senior obligations have the potential to achieve an investment-grade rating with or without credit enhancement.

''SEC. 2203. SECURED LOANS.

''(a) IN GENERAL.—

''(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements with 1 or more obligors to make secured loans, the proceeds of which shall be used—

''(A) to finance eligible project costs;

''(B) to refinance interim construction financing of eligible project costs; or

''(C) to refinance existing debt or prior project obligations;

of any project selected under section 2202.

''(2) LIMITATION ON REFINANCING OF INTERIM CONSTRUCTION FINANCING.—A loan under paragraph (1) shall not refinance interim construction financing under paragraph (1)(B) later than 1 year after the date of substantial completion of the project.

''(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

''(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a secured loan under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

''(A) the Secretary may fund an amount of the secured loan not to exceed the capital reserve subsidy amount determined under paragraph (3) prior to the obligations receiving an investment-grade rating; and

''(B) the Secretary may fund the remaining portion of the secured loan only after the obligations have received an investment-grade rating by at least 1 rating agency.

''(b) TERMS AND LIMITATIONS.—

''(1) IN GENERAL.—A secured loan under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

''(2) MAXIMUM AMOUNT.—The amount of the secured loan shall not exceed 100 percent of the reasonably anticipated eligible project costs.

''(3) PAYMENT.—The secured loan—

''(A) shall—

''(i) be payable, in whole or in part, from reliable revenue sources; and

''(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

''(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

''(4) INTEREST RATE.—The interest rate on the secured loan shall be not less than the yield on marketable United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

''(5) MATURITY DATE.—The final maturity date of the secured loan shall be not later than 30 years after the date of substantial completion of the project.

''(6) NONSUBORDINATION.—The secured loan shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

''(7) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

''(c) REPAYMENT.—

''(1) SCHEDULE.—The Secretary shall establish a repayment schedule for each secured loan under this section based on the projected cash flow from project revenues and other repayment sources.

''(2) COMMENCEMENT.—Scheduled loan repayments of principal or interest on a secured loan under this section shall commence not later than 5 years after the date of substantial completion of the project.

''(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include any revenue generated by the project.

''(4) DEFERRED PAYMENTS.—

''(A) AUTHORIZATION.—If, at any time during the 10 years after the date of substantial completion of the project, the project is unable to generate sufficient revenues to pay the scheduled loan repayments of principal and interest on the secured loan, the Secretary may, subject to subparagraph (C), allow the obligor to add unpaid principal and interest to the outstanding balance of the secured loan.

''(B) INTEREST.—Any payment deferred under subparagraph (A) shall—

''(i) continue to accrue interest in accordance with subsection (b)(4) until fully repaid; and

''(ii) be scheduled to be amortized over the remaining term of the loan beginning not later than 10 years after the date of substantial completion of the project in accordance with paragraph (1).

''(C) CRITERIA.—

''(i) IN GENERAL.—Any payment deferral under subparagraph (A) shall be contingent on the project meeting criteria established by the Secretary.

''(ii) REPAYMENT STANDARDS.—The criteria established under clause (i) shall include standards for reasonable assurance of repayment.

''(5) PREPAYMENT.—

''(A) USE OF EXCESS REVENUES.—Any excess revenues that remain after satisfying scheduled debt service requirements on the project obligations and secured loan and all deposit requirements under the terms of any trust agreement, bond resolution, reimbursement agreement, credit agreement, loan agreement, or similar agreement securing project obligations may be applied annually to prepay the secured loan without penalty.

''(B) USE OF PROCEEDS OF REFINANCING.—The secured loan may be prepaid at any time without penalty, regardless of whether such repayment is from the proceeds of refinancing from non-Federal funding sources.

''(6) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan secured under this title under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the project of—

''(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

''(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

''(C)(i) unique research resources (such as population databases); or

''(ii) an affiliation with an entity that has unique research resources.

''(d) SALE OF SECURED LOANS.—

''(1) IN GENERAL.—Subject to paragraph (2), as soon as practicable after substantial completion of a project and after notifying the obligor, the Secretary may sell to another entity or reoffer into the capital markets a secured loan for the project if the Secretary determines that the sale or reoffering can be made on favorable terms.

''(2) CONSENT OF OBLIGOR.—In making a sale or reoffering under paragraph (1), the Secretary may not change the original terms and conditions of the secured loan without the written consent of the obligor.

''(e) LOAN GUARANTEES.—

''(1) IN GENERAL.—The Secretary may provide a loan guarantee to a lender in lieu of making a secured loan if the Secretary determines that the budgetary cost of the loan guarantee is substantially the same as that of a secured loan.

''(2) TERMS.—The terms of a guaranteed loan shall be consistent with the terms set forth in this section for a secured loan, except that the rate on the guaranteed loan and any prepayment features shall be negotiated between the obligor and the lender, with the consent of the Secretary.

''SEC. 2204. LINES OF CREDIT.

''(a) IN GENERAL.—

''(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements to make available lines of credit to 1 or more obligors in the form of direct loans to be made by the Secretary at future dates on the occurrence of certain events for any project selected under section 2202.

''(2) USE OF PROCEEDS.—The proceeds of a line of credit made available under this section shall be available to pay debt service on project obligations issued to finance eligible project costs, extraordinary repair and replacement costs, operation and maintenance expenses, and costs associated with unexpected Federal or State environmental restrictions.

''(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate subsidy amount for each secured loan, taking into account such letter.

''(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a line of credit under this section shall be contingent on the project's senior obligations receiving an investment-grade rating from at least 1 rating agency.

''(b) TERMS AND LIMITATIONS.—

''(1) IN GENERAL.—A line of credit under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

''(2) MAXIMUM AMOUNTS.—

''(A) TOTAL AMOUNT.—The total amount of the line of credit shall not exceed 33 percent of the reasonably anticipated eligible project costs.

''(B) 1-YEAR DRAWS.—The amount drawn in any 1 year shall not exceed 20 percent of the total amount of the line of credit.

''(3) DRAWS.—Any draw on the line of credit shall represent a direct loan and shall be made only if net revenues from the project (including capitalized interest, any debt service reserve fund, and any other available reserve) are insufficient to pay the costs specified in subsection (a)(2).

''(4) INTEREST RATE.—The interest rate on a direct loan resulting from a draw on the line of credit shall be not less than the yield on 30-year marketable United States Treasury securities as of the date on which the line of credit is obligated.

''(5) SECURITY.—The line of credit—

''(A) shall—

''(i) be payable, in whole or in part, from reliable revenue sources; and

''(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

''(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

''(6) PERIOD OF AVAILABILITY.—The line of credit shall be available during the period beginning on the date of substantial completion of the project and ending not later than 10 years after that date.

''(7) RIGHTS OF THIRD-PARTY CREDITORS.—

''(A) AGAINST FEDERAL GOVERNMENT.—A third-party creditor of the obligor shall not have any right against the Federal Government with respect to any draw on the line of credit.

''(B) ASSIGNMENT.—An obligor may assign the line of credit to 1 or more lenders or to a trustee on the lenders' behalf.

''(8) NONSUBORDINATION.—A direct loan under this section shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

''(9) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of providing a line of credit under this section.

''(10) RELATIONSHIP TO OTHER CREDIT INSTRUMENTS.—A project that receives a line of credit under this section also shall not receive a secured loan or loan guarantee under section 2203 of an amount that, combined with the amount of the line of credit, exceeds 100 percent of eligible project costs.

''(c) REPAYMENT.—

''(1) TERMS AND CONDITIONS.—The Secretary shall establish repayment terms and conditions for each direct loan under this section based on the projected cash flow from project revenues and other repayment sources.

''(2) TIMING.—All scheduled repayments of principal or interest on a direct loan under this section shall commence not later than 5 years after the end of the period of availability specified in subsection (b)(6) and be fully repaid, with interest, by the date that is 25 years after the end of the period of availability specified in subsection (b)(6).

''(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include reliable revenue sources.

''SEC. 2205. PROJECT SERVICING.

''(a) REQUIREMENT.—The State in which a project that receives financial assistance under this title is located may identify a local servicer to assist the Secretary in servicing the Federal credit instrument made available under this title.

''(b) AGENCY; FEES.—If a State identifies a local servicer under subsection (a), the local servicer—

''(1) shall act as the agent for the Secretary; and

''(2) may receive a servicing fee, subject to approval by the Secretary.

''(c) LIABILITY.—A local servicer identified under subsection (a) shall not be liable for the obligations of the obligor to the Secretary or any lender.

''(d) ASSISTANCE FROM EXPERT FIRMS.—The Secretary may retain the services of expert firms in the field of project finance to assist in the underwriting and servicing of Federal credit instruments.

''SEC. 2206. STATE AND LOCAL PERMITS.

''The provision of financial assistance under this title with respect to a project shall not—

''(1) relieve any recipient of the assistance of any obligation to obtain any required State or local permit or approval with respect to the project;

''(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

''(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

''SEC. 2207. REGULATIONS.

''The Secretary may issue such regulations as the Secretary determines appropriate to carry out this title.

''SEC. 2208. FUNDING.

''(a) FUNDING.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this title, $49,000,000 to remain available during the period beginning on July 1, 2004 and ending on September 30, 2008.

''(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this title, not more than $2,000,000 for each of fiscal years 2004 through 2008.

''(b) CONTRACT AUTHORITY.—Notwithstanding any other provision of law, approval by the Secretary of a Federal credit instrument that uses funds made available under this title shall be deemed to be acceptance by the United States of a contractual obligation to fund the Federal credit instrument.

''(c) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

''SEC. 2209. REPORT TO CONGRESS.

''Not later than 4 years after the date of enactment of this title, the Secretary shall submit to Congress a report summarizing the financial performance of the projects that are receiving, or have received, assistance under this title, including a recommendation as to whether the objectives of this title are best served—

''(1) by continuing the program under the authority of the Secretary;

''(2) by establishing a Government corporation or Government-sponsored enterprise to administer the program; or

''(3) by phasing out the program and relying on the capital markets to fund the types of infrastructure investments assisted by this title without Federal participation.''.

SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

''CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

''SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

''(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

''(A) the acquisition of land necessary for the capital improvements;

''(B) the renovation or modernization of any building;

''(C) the acquisition or repair of fixed or major movable equipment; and

''(D) such other project expenses as the Secretary determines appropriate.

''(2) AUTHORITY TO GUARANTEE LOANS.—

''(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

''(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

''(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

''(c) FUNDING LIMITATIONS.—

''(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

''(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

''(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

''(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

''(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

''(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2008.''.

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s–3) is amended by adding at the end the following new paragraph:

''(14)(A) The term 'rural entity' includes—

''(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

''(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

''(I) a county that is not part of a metropolitan statistical area; or

''(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

''(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

''(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).''.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking ''section 1601(a)(2)(B)'' and inserting ''sections 1601(a)(2)(B) and 1603(a)(2)(B)''; and

(B) in paragraph (2)(A), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''.

SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $250,000,000 for each of fiscal years 2005 through 2008, for the purpose of making allotments under this section to States described in paragraph (1) or (2) of subsection (b). Funds appropriated under the preceding sentence shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State with respect to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall bear the same ratio to the total amount available for allotments under this paragraph for the fiscal year as the ratio of the number of undocumented alien apprehensions in the State in that fiscal year bears to the total of such numbers for all such States for such fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the 4 most recent quarterly apprehension rates for undocumented aliens in such States, as reported by the Immigration and Naturalization Service.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that is described in both of paragraphs (1) and (2) from receiving an allotment under both paragraphs for a fiscal year.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay directly to local governments, hospitals, or other providers located in the State (including providers of services received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization) that provide uncompensated emergency health services furnished to undocumented aliens during that fiscal year, and to the State, such amounts (subject to the total amount available from such allotments) as the local governments, hospitals, providers, or State demonstrate were incurred for the provision of such services during that fiscal year.

(2) LIMITATION ON STATE USE OF FUNDS.—Funds paid to a State from allotments made under subsection (b) for a fiscal year may only be used for making payments to local governments, hospitals, or other providers for costs incurred in providing emergency health services to undocumented aliens or for State costs incurred with respect to the provision of emergency health services to such aliens.

(3) INCLUSION OF COSTS INCURRED WITH RESPECT TO CERTAIN ALIENS.—Uncompensated emergency health services furnished to aliens who have been allowed to enter the United States for the sole purpose of receiving emergency health services may be included in the determination of costs incurred by a State, local government, hospital, or other provider with respect to the provision of such services.

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which States, local governments, hospitals, or other providers located in the State may apply for payments from allotments made under subsection (b) for a fiscal year for uncompensated emergency health services furnished to undocumented aliens during that fiscal year.

(B) INCLUSION OF MEASURES TO COMBAT FRAUD.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that fraudulent payments are not made from the allotments determined under subsection (b).

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) shall allow for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term ''hospital'' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

(2) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ''Indian tribe'' and ''tribal organization'' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(3) PROVIDER.—The term ''provider'' includes a physician, any other health care professional licensed under State law, and any other entity that furnishes emergency health services, including ambulance services.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(5) STATE.—The term ''State'' means the 50 States and the District of Columbia.

SEC. 611. INCREASE IN APPROPRIATION TO THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by striking ''and'' at the end; and

(B) by striking subclause (III), and inserting the following new subclauses:

''(III) for fiscal year 2004, the limit for fiscal year 2003 increased by $10,000,000;

''(IV) for fiscal year 2005, the limit for fiscal year 2003 increased by $15,000,000;

''(V) for fiscal year 2006, the limit for fiscal year 2003 increased by $25,000,000; and

''(VI) for each fiscal year after fiscal year 2006, the limit for fiscal year 2003.''; and

(2) in clause (ii)—

(A) in subclause (VI), by striking ''and'' at the end;

(B) in subclause (VII)—

(i) by striking ''each fiscal year after fiscal year 2002'' and inserting ''fiscal year 2003''; and

(ii) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(VIII) for fiscal year 2004, $170,000,000;

''(IX) for fiscal year 2005, $175,000,000;

''(X) for fiscal year 2006, $185,000,000; and

''(XI) for each fiscal year after fiscal year 2006, not less than $150,000,000 and not more than $160,000,000.''.

SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE CLAIMS ACT.

(a) IN GENERAL.—Section 3729(a) of title 31, United States Code, is amended—

(1) by striking ''$5,000'' and inserting ''$7,500''; and

(2) by striking ''$10,000'' and inserting ''$15,000''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

SEC. 613. INCREASE IN CIVIL MONETARY PENALTIES UNDER THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), in the matter following paragraph (7), is amended—

(1) by striking ''$10,000'' each place it appears and inserting ''$12,500'';

(2) by striking ''$15,000'' and inserting ''$18,750''; and

(3) striking ''$50,000'' and inserting ''$62,500''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

TITLE VII—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 701. SHORT TITLE.

This title may be cited as the ''Greater Access to Affordable Pharmaceuticals Act''.

SEC. 702. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

''(B) NOTICE OF OPINION THAT PATENT IS NOT VALID OR WILL NOT BE INFRINGED.—

''(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

''(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

''(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

''(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(II) the holder of the approved application under subsection (b) for the drug that is

claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

''(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is not valid or will not be infringed.''; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking ''under the following'' and inserting ''by applying the following to each certification made under paragraph (2)(A)(vii)''; and

(ii) in clause (iii)—

(I) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines is substantially complete, was submitted.''; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

''(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(aa) the date on which the court enters judgment reflecting the decision; or

''(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(bb) by striking subclause (II) and inserting the following:

''(II) if before the expiration of such period the district court decides that the patent has been infringed—

''(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

''(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(cc) in subclause (III), by striking ''on the date of such court decision.'' and inserting ''as provided in subclause (I); or''; and

(dd) by inserting after subclause (III) the following:

''(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II).'';

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

''(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under paragraph (2)(B) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).''.

(b) APPLICATIONS GENERALLY.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b), by striking paragraph (3) and inserting the following:

''(3) NOTICE OF OPINION THAT PATENT IS NOT VALID OR WILL NOT BE INFRINGED.—

''(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

''(B) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

''(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

''(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

''(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is not valid or will not be infringed.''; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking ''under the following'' and inserting ''by applying the following to each certification made under subsection (b)(2)(A)(iv)'';

(B) in subparagraph (C)—

(i) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.'';

(ii) in the second sentence—

(I) by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(II) by striking clause (i) and inserting the following:

''(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(I) the date on which the court enters judgment reflecting the decision; or

''(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(III) by striking clause (ii) and inserting the following:

''(ii) if before the expiration of such period the district court decides that the patent has been infringed—

''(I) if the judgment of the district court is appealed, the approval shall be made effective on—

''(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(II) if the judgment of the district court is not appealed or is affirmed, the approval

shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(IV) in clause (iii), by striking ''on the date of such court decision.'' and inserting ''as provided in clause (i); or''; and

(V) by inserting after clause (iii), the following:

''(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii).''; and

(iii) in the third sentence, by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

''(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).''.

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

''(5) The filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought by the applicant under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.''.

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 703. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section ___02) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

''(iv) 180-DAY EXCLUSIVITY PERIOD.—

''(I) DEFINITIONS.—In this paragraph:

''(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

''(bb) FIRST APPLICANT.—The term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

''(cc) SUBSTANTIALLY COMPLETE APPLICATION.—The term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

''(dd) TENTATIVE APPROVAL.—

''(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

''(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

''(II) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant.''; and

(2) by inserting after subparagraph (C) the following:

''(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

''(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

''(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

''(aa) the earlier of the date that is—

''(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

''(BB) 30 months after the date of submission of the application of the first applicant; or

''(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

''(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

''(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

''(CC) The patent expires.

''(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

''(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

''(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

''(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

''(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or

an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

''(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

''(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

''(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

''(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

''(II) no applicant shall be eligible for a 180-day exclusivity period.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term ''decision of a court'' as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 704. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

''(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

''(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action.''; and

(2) by adding at the end the following:

''(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.''.

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 705. REMEDIES FOR INFRINGEMENT.

Section 287 of title 35, United States Code, is amended by adding at the end the following:

''(d) CONSIDERATION.—In making a determination with respect to remedy brought for infringement of a patent that claims a drug or a method or using a drug, the court shall consider whether information on the patent was filed as required under 21 U.S.C. 355 (b) or (c), and, if such information was required to be filed but was not, the court may refuse to award treble damages under section 284.''.

SEC. 706. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking ''(j)(5)(D)(ii)'' each place it appears and inserting ''(j)(5)(F)(ii)'';

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking ''(j)(5)(D)'' each place it appears and inserting ''(j)(5)(F)''; and

(3) in subsections (e) and (l), by striking ''505(j)(5)(D)'' each place it appears and inserting ''505(j)(5)(F)''.

TITLE VIII—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 801. IMPORTATION OF PRESCRIPTION DRUGS.

(A) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

''SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

''(a) DEFINITIONS.—In this section:

''(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

''(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

''(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

''(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

''(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

''(C) an infused drug (including a peritoneal dialysis solution);

''(D) an intravenously injected drug; or

''(E) a drug that is inhaled during surgery.

''(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

''(5) WHOLESALER.—

''(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

''(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

''(b) REGULATIONS.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

''(c) LIMITATION.—The regulations under subsection (b) shall—

''(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

''(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

''(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

''(d) INFORMATION AND RECORDS.—

''(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

''(A) The name and quantity of the active ingredient of the prescription drug.

''(B) A description of the dosage form of the prescription drug.

''(C) The date on which the prescription drug is shipped.

''(D) The quantity of the prescription drug that is shipped

''(E) The point of origin and destination of the prescription drug.

''(F) The price paid by the importer for the prescription drug.

''(G) Documentation from the foreign seller specifying—

''(i) the original source of the prescription drug; and

''(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

''(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

''(I) The name, address, telephone number, and professional license number (if any) of the importer.

''(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

''(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

''(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

''(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

''(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

''(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

''(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

''(i) is approved for marketing in the United States; and

''(ii) meets all labeling requirements under this Act.

''(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

''(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

''(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

''(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

''(e) TESTING.—The regulations under subsection (b) shall require—

''(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

''(2) if the tests are conducted by the importer—

''(A) that information needed to—

''(i) authenticate the prescription drug being tested; and

''(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

''(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

''(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

''(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

''(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

''(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

''(i) PROHIBITION OF DISCRIMINATION.—

''(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

''(2) DISCRIMINATION.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

''(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

''(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

''(j) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

''(k) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—

''(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

''(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

''(B) exercise discretion to permit individuals to make such importations in circumstances in which—

''(i) the importation is clearly for personal use; and

''(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

''(2) WAIVER AUTHORITY.—

''(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

''(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

''(3) DRUGS IMPORTED FROM CANADA.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

''(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

''(B) is accompanied by a copy of a valid prescription;

''(C) is imported from Canada, from a seller registered with the Secretary;

''(D) is a prescription drug approved by the Secretary under chapter V;

''(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

''(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

''(l) STUDIES; REPORTS.—

''(1) BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES.—

''(A) STUDY.—

''(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

''(I) importations of prescription drugs made under the regulations under subsection (b); and

''(II) information and documentation submitted under subsection (d).

''(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—

''(I) evaluate the compliance of importers with the regulations under subsection (b);

''(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

''(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

''(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(2) BY THE COMPTROLLER GENERAL.—

''(A) STUDY..—he Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

''(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

''(n) EFFECTIVENESS OF SECTION.—

''(1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

''(2) PROCEDURE.—The Secretary shall not submit a certification under paragraph (1) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

''(A)(i) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

''(ii) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

''(iii) identifies specifically the causes of the increased risk; and

''(iv)(I) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

''(II) if the Secretary determines that any measures described in subclause (I) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

''(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

''(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

''(ii) determines that the benefits do not outweigh the detriment.

''(o) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.''.

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking ''covered product in violation of section 804'' and inserting ''prescription drug in violation of section 804''; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking ''covered product pursuant to section 804(a)'' and inserting ''prescription drug under section 804(b)''.

TITLE IX—OFFSET

SEC. 901. INCREASE IN MEDICAID BEST PRICE REBATE PERCENTAGE.

Section 1927(c)(1)(B)(i) (42 U.S.C. 1396r–8(c)(1)(B)(i)) is amended—

(1) in subclause (IV), by striking ''and'' at the end;

(2) in subclause (V)—

(A) by inserting ''and before January 1, 2004,'' after ''December 31, 1995,''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(V) after December 31, 2003, is 20 percent.''.

Make such changes in subsidy payments to employers under 1860D–21, as added by section 101, to ensure that the total cost of this Act does not exceed $393,000,000,000 during the 10-fiscal-year period that begins on October 1, 2003.

Mr. THOMPSON of California (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

The SPEAKER pro tempore. The gentleman from California (Mr. THOMPSON) is recognized for 5 minutes on his motion to recommit.

Mr. THOMPSON of California. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, during tonight's debate we have heard a number of times the Democrats do not have a feasible Medicare prescription drug proposal. This is just not true. The Blue Dogs have a motion to recommit that offers a real and an affordable prescription drug alternative, and it does so without calling for an end of Medicare. And we have included strong safeguard language that specifically instructs the Secretary to keep the costs of this measure within the $400 billion budget window. The Blue Dog motion to recommit provides Medicare fallback, unlike the Republican bill, protects traditional fee for service Medicare, unlike the Republican bill, and provides billions of dollars of relief for rural providers.

Unfortunately, for America's seniors, our proposal will only get 5 minutes of discussion tonight, 5 minutes to protect Medicare from privatization, 5 minutes to ensure rural seniors have a benefit if the PPOs do not come to their areas. And for all of the Members tonight who have said they are supporting the Republican bill in order to move the debate, the best way to do that is to support this recommit so we can promptly get a measure back here in the morning to vote on.

□ 0115

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I rise in humble appreciation for the 45 seconds being allowed to me tonight to speak for what I am for in Medicare and to express my extreme disappointment in the leadership of this House for bringing to the floor a bill based on an ideological agenda that will undermine the traditional Medicare program and fail to offer reliable prescription drug coverage for seniors in rural areas, or seriously address the issue of prescription drug costs.

The motion to recommit promptly reported back to the floor will have a guaranteed fallback within Medicare for rural areas if private plans are not available, stronger provisions for rural providers, stays within the $400 billion allocation which safeguards to make sure that that happens, and it is based on the compromise in the other body that will give strong bipartisan support and become law.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentleman from Tennessee (Mr. TANNER).

Mr. TANNER. Mr. Speaker, I did not vote for the Democratic substitute because I thought it was too light on reform. The Republican bill is too light on substance.

Mr. Speaker, we have a middle ground here, if we were only allowed to offer it; and it is what the gentleman from Texas (Mr. STENHOLM) said. Basically, any meaningful reform in the Medicare or health care area, the crux of that matter is, one, a Federal backstop for rural America, which is not in the bill we are considering; and, two, some measure of cost containment. That is how we save the program. Neither one of these essential elements in my judgment is in the bill. If we could get this motion to recommit, we could fix it and we could come back here with strong bipartisan support.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT of Georgia. Mr. Speaker, I say to my colleagues, I plead with my colleagues to let us have this opportunity to recommit. We have had so much debate where we have talked about the cost of these plans, and I thought it was an unfair dig at my good friends, the gentleman from New York (Mr. RANGEL) and the gentleman from Michigan (Mr. DINGELL), and their bill being $1 trillion. That was not true, because there was no effort to put the cost containment in.

But we and the Blue Dogs have put together a budget; we put together a plan at $400 billion that falls right within the issue.

This is an important issue to all the people of this Nation. And here we are at 1:30 in the morning on my birthday. But I will tell my colleagues this: I could not find a better thing to do on my birthday than to be down here fighting for these seniors, that the Democratic Party has been fighting for ever since we have had a Democratic Party. I would hope that we would get this opportunity to recommit.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Vermont (Mr. SANDERS).

Mr. SANDERS. Mr. Speaker, I am not really a Blue Dog.

Mr. Speaker, the Republican proposal ignores the most important prescription drug issue facing our country: cost containment and the need to end the national disgrace by which our citizens are forced to pay, by far, the highest prices in the world for prescription drugs. If we do not pass this motion to recommit, the pharmaceutical industry will have succeeded in keeping prices high and their profits high.

This motion to recommit removes the poison pill in H.R. 1, the so-called Cochran amendment, and establishes a real prescription drug reimportation program with Canada. This provision alone, without costing the taxpayers one penny, will do more to help seniors and all Americans get affordable drugs than the $400 billion being spent by the Republicans.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Illinois (Mr. EMANUEL), who is not a Blue Dog, but knows a good deal when he sees one.

Mr. EMANUEL. Mr. Speaker, the speaker earlier talked about using competition and market forces. This bill allows competition between generics versus name brand, so we get the best price. It allows us to have competition whether we want to buy here in the United States, England, France, or Germany, and allows competition between those prices. It would save money. It uses market forces to reduce prices.

Third, it allows the Secretary of HHS to get the best available price, just like all of the Sam's Clubs all over America. It does that here. It allows competition and market forces to reduce prices.

These provisions have, in the past, received bipartisan support. They should receive bipartisan support today because they represent our common

principles of reducing prices and making medications affordable to all Americans.

Mr. THOMPSON of California. Mr. Speaker, I urge this body to vote to send this motion back to committee and promptly report back a solid Medicare prescription drug benefit that we can pass tomorrow.

Mr. THOMAS. Mr. Speaker, I rise in opposition to the motion to recommit.

I do want to announce that today is the gentleman from Iowa's (Mr. NUSSLE) birthday as well.

As my colleagues know, I have a reputation for reading legislation. I apologize. As I began reading the motion to recommit, as I got to page 3, the comment of the gentleman from Vermont ringing in my ears, about how they are really concerned about cost containment.

It turns out subtitle D has been scratched from the bill, my colleagues might like to know. It contains section 131, additional requirements for annual financial report and oversight on the Medicare program. Section 132, trustee report on Medicare's unfunded obligations. That has been scratched from the bill.

And I continued to try to go through; but, actually, you only need the front page. My colleagues heard them say over and over again: ''promptly.'' We know by now: ''forthwith,'' ''it works.'' ''It comes back, we can vote on it.''

I say: promptly, it does not mean a thing.

Vote ''no'' on the motion to recommit.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. THOMPSON of California. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 208, noes 223, not voting 4, as follows:

[Roll No. 331]

AYES—208

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Wamp
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOES—223

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

NOT VOTING—4

LaTourette
McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 0138

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. LEVIN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote will be followed by a 5-minute vote on H.R. 2417.

The vote was taken by electronic device, and there were—ayes 216, noes 215, answered ''present'' 1, not voting 3, as follows:

[Roll No. 332]

AYES—216

Aderholt
Akin
Alexander
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach

Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Houghton
Hulshof
Hunter
Hyde
Isakson
Israel
Issa
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Matheson
McCotter
McCrery
McHugh
McKeon
Mica
Miller (MI)
Miller, Gary
Murphy
Myrick
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Saxton
Schrock
Sessions
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

NOES—215

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Burr
Burton (IN)
Buyer
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
DeMint
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Gutknecht
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hostettler
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lynch
Majette
Maloney
Markey
Marshall
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (FL)
Miller (NC)
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murtha
Musgrave
Nadler
Napolitano
Neal (MA)
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Pence
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Ryun (KS)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Shadegg
Sherman
Skelton
Slaughter
Smith (MI)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tancredo
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

ANSWERED ''PRESENT''—1

Istook

NOT VOTING—3

McInnis Smith (WA) Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 0233

Live pair:
On this vote:

Mr. ISTOOK with Mr. YOUNG of Florida:

Mr. ISTOOK. Mr. Speaker, on my vote just recorded I voted ''no.'' I have a pair with the gentleman from Florida, Mr. YOUNG, who is at a funeral, and desire to change my vote and be recorded as ''present.''

''Mr. OTTER and Mrs. EMERSON changed their vote from ''no'' to ''aye.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to section 3 of House Resolution 299, the text of H.R. 2596 will be appended to the engrossment of H.R. 1; and H.R. 2596 shall be laid on the table.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The pending business is the question of the passage of the bill, H.R. 2417, on which further proceedings were postponed earlier today.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the passage of the bill on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 410, nays 9, not voting 15, as follows:

[Roll No. 333]

YEAS—410

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Regula

Rehberg	Shadegg	Tiahrt
Renzi	Shaw	Tiberi
Reyes	Shays	Tierney
Reynolds	Sherman	Toomey
Rodriguez	Sherwood	Towns
Rogers (AL)	Shimkus	Turner (OH)
Rogers (KY)	Shuster	Turner (TX)
Rogers (MI)	Simmons	Udall (CO)
Rohrabacher	Simpson	Udall (NM)
Ros-Lehtinen	Skelton	Upton
Ross	Slaughter	Van Hollen
Rothman	Smith (MI)	Velazquez
Roybal-Allard	Smith (NJ)	Visclosky
Royce	Smith (TX)	Vitter
Ruppersberger	Snyder	Walden (OR)
Rush	Solis	Walsh
Ryan (OH)	Souder	Wamp
Ryan (WI)	Spratt	Watson
Ryun (KS)	Stearns	Watt
Sabo	Stenholm	Waxman
Sanchez, Linda T.	Strickland	Weiner
	Stupak	Weldon (FL)
Sanchez, Loretta	Sullivan	Weldon (PA)
Sanders	Sweeney	Weller
Sandlin	Tanner	Wexler
Saxton	Tauscher	Whitfield
Schakowsky	Tauzin	Wicker
Schiff	Taylor (MS)	Wilson (NM)
Schrock	Taylor (NC)	Wilson (SC)
Scott (GA)	Terry	Wolf
Scott (VA)	Thomas	Woolsey
Sensenbrenner	Thompson (CA)	Wu
Serrano	Thompson (MS)	Wynn
Sessions	Thornberry	Young (AK)

NAYS—9

Capuano	Filner	Owens
Duncan	Kucinich	Paul
Fattah	Lewis (GA)	Waters

NOT VOTING—15

Baker	Manzullo	Rangel
DeFazio	McInnis	Smith (WA)
Dicks	Musgrave	Stark
Garrett (NJ)	Myrick	Tancredo
Jones (NC)	Radanovich	Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. OSE) (during the vote). The Chair announces that one panel on the board is not operational and Members may confirm their votes at the voting stations.

□ 0242

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PROVIDING FOR AN ADJOURNMENT OR RECESS OF THE TWO HOUSES

Mr. DELAY. Mr. Speaker, pursuant to section 5 of House Resolution 299, I send to the desk a concurrent resolution (H. Con. Res. 231) and ask for its immediate consideration.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 231

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on the legislative day of Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Monday, July 7, 2003, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Monday, July 7, 2003, or at such other time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate whenever, in their opinion, the public interest shall warrant it.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

CONDITIONAL ADJOURNMENT OF THE HOUSE TO TUESDAY, JULY 1, 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its concurrence in House Concurrent Resolution 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY, JULY 9, 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday, July 9, 2003.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

□ 0245

APPOINTMENT OF HON. TOM DAVIS OF VIRGINIA TO ACT AS SPEAKER PRO TEMPORE TO SIGN ENROLLED BILLS AND JOINT RESOLUTIONS THROUGH JULY 7, 2003

The SPEAKER pro tempore laid before the House the following Communication from the Speaker:

WASHINGTON, DC,
June 26, 2003.

I hereby appoint the Honorable TOM DAVIS to act as Speaker pro tempore to sign enrolled bills and joint resolutions through July 7, 2003.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

The SPEAKER pro tempore (Mr. OSE). Without objection, the appointment is approved.

There was no objection.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 3364

Mr. MICHAUD. Mr. Speaker, I ask unanimous consent that my name be removed as cosponsor of H.R. 2407.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Maine?

There was no objection.

HONORING THE NORTHWESTERN BAND OF THE SHOSHONE NATION

(Mr. BISHOP of Utah asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BISHOP of Utah. Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout northern Utah and southern Idaho, and specifically to pay tribute to this tribe as it enters a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that consumes my district as well as the districts of my colleagues in Idaho and Nevada. Last month, the Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it is called, was the worst slaughter of Native Americans west of the Mississippi, with an estimate of double the number of deaths of those at Wounded Knee. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a solemn and very moving ceremony, the Northwestern Band of the Shoshone Nation was able to perform burial rites for the men, women and children who died on that site 140 years ago. Mr. Speaker, today I wish to honor those members of this tribe who gave their lives on that day in 1863.

I also want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this issue.

Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout Northern Utah and Southern Idaho, and to pay tribute to this tribe as it celebrates a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that makes up my district—and the districts of my colleagues from Idaho and Nevada. Last month, the Northwestern Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it

is called, was the worst slaughter west of the Mississippi of Native Americans, with estimates of the dead nearly double those of Wounded Knee, South Dakota. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a solemn and moving ceremony, the Northwestern Band of the Shoshone Nation was able to perform burial rites for the men, women, and children who died on that site over 140 years ago. Mr. Speaker, today I wish to honor those members of the tribe who gave their lives on that day in 1863.

I want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this episode in our nation's history. Their goal is to obtain a total of 150 acres so that the Bear River Massacre site can be turned into a memorial. This story, along with the tribe's history and culture, will be preserved and shared with the public at the nearby American West Heritage Center in Wellsville, Utah, which is also located in my district.

Mr. Speaker, for the benefit of our colleagues, I am also submitting an article for the RECORD from a Salt Lake newspaper, which details the history of this site. I commend the past and current Shoshone leadership for their vision and efforts.

[From the Salt Lake Tribune, Feb. 4, 2003]

THIS HALLOWED GROUND

It never made any sense to call what happened at Idaho's Bear River 140 years ago a ''battle.'' When soldiers based in Salt Lake City went on a mad rampage and killed at least 250 men, women and children of the Northwestern Shoshone tribe on Jan. 29, 1863, it was a massacre.

And it still makes no sense that the site of that blot on our shared history is not officially designated as a national historic site.

Descendants of the Northwestern Shoshone see the historic significance of the place, and so does the National Park Service. But, while the site near Preston in southeastern Idaho drew a small crowd of devoted friends to mark Wednesday's anniversary of the horrible event, what happened there remains something that has been largely air-brushed, Stalin-like, from our official memory.

The stumbling block, apparently, is that Idaho Sen. Larry Craig has for eight years been bottling up a resolution to create a $14 million Bear River National Historic Site and Visitors Center. Craig says the park service has more immediate needs and, given the constant scuffle within all federal agencies for adequate funding, it is true that not every idea for a new national historic site can be fulfilled.

But the Bear River massacre is important enough that it needs to be burned into our collective memory. It was one of the earliest and one of the bloodiest encounters between Native Americans and European settlers in the Far West. Its memory has been kept alive by the tireless efforts of a few Shoshone, most notably Utah's Mae Timbimboo Parry, efforts that themselves deserve to be chronicled at an official historic site.

As the United States gears up to mark the 200th anniversary of Lewis and Clark's Corps of Discovery, with proper notice given to their Shoshone guide Sacagawea, now would be the proper time to note this terribly sad bit of fallout from that courageous expedition. The extra amount of attention that will be focused on Lewis and Clark should be used to earn support from historians, Congress, foundations and the general public to properly mark the site of the Bear River Massacre and formally mourn those who died there.

The place of the Bear River Massacre is a national historic site, whether we say so or not.

We should say so.

THE CRISIS IN LIBERIA

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in response to the troubling situation of unrest in our ally nation of Liberia. Because of the rich history of its birth in 1820 with the valiant acts of freed American slaves in founding the capital of Christopolis, now Monrovia, we certainly have a stake in the need for restoring peace.

Since the end of the seven-year civil war that claimed the lives of over 250,000 people, more than 1.3 million residents have had to flee the country for refuge in neighboring countries, many of which have already reached the end of their meager resources. The series of events in Liberia presents a harsh irony in light of yesterday's events: we celebrated a Constitutional victory in the Grutter v. Bollinger decision that came out of the highest court in the nation. Similarly ironic, on that same day, we saluted the Honorable Mayor Maynard Jackson, Jr., one of the most charismatic civic leaders of all time in his departure at age 65. This ironic juxtaposition of emotions reminds us that no matter how far we think we've gotten, there is always distance to be traveled in the work of making peace in the world.

The U.N. High Court indictment of Liberian President Charles Taylor on charges of crimes against humanity, largely stemming from his participaion in the civil war in Sierra Leone, has created a panic in Monrovia. A Liberian woman stated that ''We are all tired of Charles Taylor, but we are afraid that his arrest in Ghana will create chaos.'' We in the United States now know the feeling of panic as we check the terror threat on a daily basis—today's threat level being Yellow, or ''heightened.'' People shouldn't have to live in fear.

The economic effect of the renewed arms embargo, ban on dealing in rough diamonds, and airline restrictions on Liberia will be substantial for the citizens and business community. However, the human rights abuses such as summary executions, recruitment of child soldiers. sexual violence, looting of civilian property, and forced labor must end now. The mass evacuation aboard the French vessel *Orage* of the hundreds of foreigners, including Americans, holding dual U.S. and Liberian citizenship, Europeans, Lebanese, Ivorian and Indian nationals, Egyptians, and some Africans represents a departure from our goal of uniting our international community in peace. It is a moral imperative that we end the chaos caused by anarchy and criminal behavior. The Ceasefire Agreement between the Republic of Liberia, the Liberians United for Reconciliation and Democracy (LUR) groups, and the Movement for Democracy in Liberia (MODEL) is a start, but our help is imperative. We must make our voices heard and incite action from our colleagues in order to restore peace.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. WYNN (at the request of Ms. PELOSI) for today until 11:00 a.m. on account of personal business.

Mr. YOUNG of Florida (at the request of Mr. DELAY) for today from 6:00 p.m. and the balance of the week on account of attending a funeral.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Member (at the request of Ms. JACKSON-LEE of Texas) to revise and extend their remarks and include extraneous material:)

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 163. An act to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes; to the Committee on Education and the Work Force and the Committee on Resources.

S. 498. An act to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine, in recognition of his contributions to the Nation; to the Committee on Financial Services.

S. 867. An act to designate the facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, as the ''Ronald Reagan Post Office Building''; to the Committee on Government Reform.

ENROLLED BILLS SIGNED

Mr. Trandahl, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 825. An act to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the ''Michael J. Healy Post Office Building''.

H.R. 917. An act to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the ''Floyd Spence Post Office Building''.

H.R. 925. An act to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the ''Cesar Chavez Post Office''.

H.R. 981. An act to designate the facility of the United States Postal Service located at

141 Erie Street in Linesville, Pennsylvania, as the ''James R. Merry Post Office''.

H.R. 985. An act to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the ''Delbert L. Latta Post Office Building''.

H.R. 1055. An act to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the ''Dr. Roswell N. Beck Post Office Building''.

H.R. 1368. An act to designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the ''Norman D. Shumway Post Office Building''.

H.R. 1465. An act to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the ''General Charles Gabriel Post Office''.

H.R. 1596. An act to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the ''Timothy Michael Gaffney Post Office Building''.

H.R. 1609. An act to designate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the ''Admiral Donald Davis Post Office Building''.

H.R. 1740. An act to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the ''Dr. Caesar A.W. Clark, Sr. Post Office Building''.

H.R. 2030 An act to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the ''Patsy Takemoto Mink Post Office Building''.

SENATE ENROLLED BILL SIGNED

The Speaker announced his signature on an enrolled bill of the Senate of the following title:

S. 858. A act to extend the Abraham Lincoln Bicentennial Commission and for other purposes.

ADJOURNMENT

Mr. DELAY. Mr. Speaker, pursuant to House Concurrent Resolution 231, I move that the House do now adjourn.

The motion was agreed to.

The SPEAKER pro tempore. Pursuant to the previous order of the House of today, the House stands adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

Thereupon (at 2 o'clock and 47 minutes a.m. Friday, June 27, 2003, legislative day of June 26, 2003), pursuant to the previous order of the House of today, the House adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2886. A letter from the Deputy Secretary, Department of Defense, transmitting notification of munitions disposal, pursuant to 50 U.S.C. 1512(4); to the Committee on Armed Services.

2887. A letter from the Acting Under Secretary, Department of Defense, transmitting a report on the results of an evaluation of the programmatic impact of combining funding and administration for the Historically Black Colleges and Universities and Minority Institutions program, the Hispanic-Serving Institutions program, and the American Indian Tribal Colleges program; to the Committee on Armed Services.

2888. A letter from the Secretary, Department of Transportation, transmitting The Department's annual report as required by the Superfund Amendments and Reauthorization Act (SARA) of 1986, as amended, pursuant to 42 U.S.C. 9620; to the Committee on Energy and Commerce.

2889. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Natural Emission Standards for Hazardous Air Pollutants for Source Categories: General Provisions; and Requirements for Control Technology Determinations for Major Sources in Accordance with Clean Air Act Sections, Sections 112(g) and 112(j) [FRL-7498-8] (RIN: 2060-AK52) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2890. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of State Air Quality Plans for Designated Facilities and Pollutants; State of West Virginia; Control of Emissions from Existing Small Municipal Waste Combustion Units [WV06-6027a; FRL-7503-2] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2891. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of State Plans For Designated Facilities and Pollutants: Vermont; Negative Declaration [VT-1226a; FRL-7502-1] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2892. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval of the Clean Air Act, Section 112(I), Authority for Hazardous Air Pollutants: Management and Control of Asbestos Disposal Sites Not Operated After July 9, 1981: State of New Hampshire Department of Environmental Services [FRL-7490-6] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2893. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Revisions to Regional Haze Rule to Incorporate Sulfur Dioxide Milestones and Backstop Emissions Trading Program for Nine Western States and Eligible Indian Tribes Within that Geographic Area [FRL-7504-4] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2894. A letter from the Acting Prinicpal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Standards of Performance for Stationary Gas Turbines [OAR-2002-0053, FRL-7502-4] (RIN: 2060-AK35) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2895. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — National Emission Standards for Hazardous Air Pollutants for Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-Alone Semichemical Pulp Mills [OAR-2002-0045, FRL-7502-7] (RIN: 2060-AK53) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2896. A letter from the Director, Defense Security Cooperation Agency, transmitting the Department of Defense's proposed lease of defense articles to the Government of the Hashemite Kingdom of Jordan (Transmittal No. 02-03), pursuant to 22 U.S.C. 2796a(a); to the Committee on International Relations.

2897. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting notification that effective May 18, 2003 a 25% danger pay allowance has been designated for Saudi Arabia, pursuant to 5 U.S.C. 5928; to the Committee on International Relations.

2898. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting the FY 2002 Annual Report on U.S. Government Assistance to and Cooperative Activities with Eurasia; to the Committee on International Relations.

2899. A letter from the Assistant Attorney General, Department of Justice, transmitting the Department's proposed legislation relating to sexual abuse and contraband offenses relating to Federal prisoners; to the Committee on the Judiciary.

2900. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Airbus Model A319-131, -132, and -133; A320-232 and -233; and A321-231 Series Airplanes; Equipped with International Aero Engines (IAE) V25()()-A5 Engines [Docket No. 2003-NM-124-AD; Amendment 39-13159; AD 2003-10-14] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2901. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dassault Model Mystere-Falcon 50 Series Airplanes [Docket No. 2003-NM-118-AD; Amendment 39-13149; AD 2003-10-04] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2902. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 390 Airplanes [Docket No. 2003-CE-17-AD; Amendment 39-13150; AD 2003-10-05] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2903. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; CFM International (CFMI) CFM56-5C Series Turbofan Engines [Docket No. 95-ANE-64-AD; Amendment 39-13094; AD 97-09-02R2] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2904. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dornier-Werke G.m.b.H. Model Do 27 Q-6 Airplanes [Docket No. 2002-CE-55-AD; Amendment 39-13096; AD 2003-06-08] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2905. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; SOCATA — Groupe AEROPATIALE Models MS 892A-150, MS 892E-150, MS 893A, MS 893E, MS 894E, Rallye 150T, and Rallye 150ST Airplanes [Docket No. 2002-CE-49-AD; Amendment 39-13095; AD 2003-06-07] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2906. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 440) Series Airplanes [Docket No. 2002-NM-100-AD; Amendment 39-13070; AD 2003-04-21] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2907. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dornier Model 328-100 and -300 Series Airplanes [Docket No. 2002-NM-218-AD; Amendment 39-13084; AD 2003-05-08] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2908. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HC-C2Y(K,R)-1BF/F8477- Propellers [Docket No. 2001-NE-47-AD; Amendment 39-13089; AD 2003-06-02] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2909. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Fokker Model F.28 Mark 0070 and 0100 Series Airplanes [Docket No. 2001-NM-289-AD; Amendment 39-13068; AD 2003-04-19] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2910. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-90-30 Airplanes [Docket No. 2001-NM-212-AD; Amendment 39-13067; AD 2003-04-18] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2911. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dowty Aerospace Propellers, Models R354, R375, R389, and R390 Propellers [Docket No. 2000-NE-18-AD; Amendment 39-13074; AD 2003-04-25] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2912. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HC-B3TN-5() Propellers [Docket No. 2001-NE-44-AD; Amendment 39-13072; AD 2003-04-23] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2913. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HD-E6C-3B/E13890K [Docket No. 2000-NE-60-AD; Amendment 39-13071; AD 2003-04-22] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2914. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2C10 Series Airplanes [Docket No. 2002-NM-93-AD; Amendment 39-13076; AD 2003-04-27] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2915. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 1900D Airplanes [Docket No. 2002-CE-32-AD; Amendment 39-13075; AD 2003-04-26] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2916. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada (Bell) Model 427 Helicopters [Docket No. 2002-SW-19-AD; Amendment 39-13063; AD 2003-04-14] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2917. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Fokker Model F.28 Mark 1000, 2000, 3000, and 4000 Series Airplanes [Docket No. 2001-NM-334-AD; Amendment 39-13057; AD 2003-04-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2918. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model SA341G and SA342J Helicopters [Docket No. 2002-SW-47-AD; Amendment 39-13062; AD 2003-04-13] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2919. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada Limited Model 427 Helicopters [Docket No. 2001-SW-43-AD; Amendment 39-13061; AD 2003-04-12] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2920. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Agusta S.p.A. Model A109E Helicopters [Docket No. 2002-SW-55-AD; Amendment 39-13060; AD 2002-25-51] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2921. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Sikorsky Aircraft Corporation Model S-76A, B, and C Helicopters [Docket No. 2003-SW-06-AD; Amendment 39-13064; AD 2003-04-15] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2922. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-90-30 Airplanes [Docket No. 2001-NM-389-AD; Amendment 39-13058; AD 2003-04-10] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2923. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 100 & 440) Airplanes [Docket No. 2002-NM-100-AD; Amendment 39-13070; AD 2003-04-21 R1] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2924. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model 717-200 Airplanes [Docket No. 2002-NM-353-AD; Amendment 39-13073; AD 2003-04-24] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2925. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Schweizer Aircraft Corporation Model 269D Helicopters [Docket No. 2002-SW-57-AD; Amendment 39-13134; AD 2003-09-05] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2926. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model DC-9-10, -20, -30, -40, and -50 Series Airplanes; and DC-9-81 (MD-81), DC-9-82 (MD-82), DC-9-83 (MD-83), DC-9-87 (MD-87), and MD-88 Airplanes [Docket No. 2001-NM-170-AD; Amendment 39-13136; AD 2003-09-07] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2927. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Cessna Aircraft Company Models 441 and F406 Airplanes [Docket No. 2002-CE-18-AD; Amendment 39-13138; AD 2003-09-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2928. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd & Co KG Models BR700-710A1-10 and BR700-710A2-20 Turbofan Engines; Correction [Docket No. 2000-NE-48-AD; Amendment 39-13107; AD 2003-07-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2929. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd & Co KG Models BR700-710A1-10 and BR700-710A2-20 Turbofan Engines [Docket No. 2000-NE-48-AD; Amendment 39-13107; AD 2003-07-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2930. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Corporation (Formerly Allison Engine Company) 501-D Series Turboprop Engines [Docket No. 2001-NE-01-AD; Amendment 39-13098; AD 2003-07-02] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2931. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 747-200B and -200F Series Airplanes Powered by Pratt & Whitney JT9D-70 Series Engines [Docket No. 2002-NM-23-AD; Amendment 39-13059; AD 2003-04-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2932. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Model DH.125, HS.125, and BH.125 Series Airplanes; Model BAe.125 Series 800A, 800A (C-29A), 800A (U-125), 800B, 1000A, and 1000B Airplanes; and Model Hawker 800, 800 (including variant U-125A), 1000, and 800XP Airplanes [Docket No. 2002-NM-15-AD; Amendment 39-13069; AD 2003-04-20] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2933. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Beech Models 1900, 1900C, and 1900D Airplanes [Docket No. 2003-CE-07-AD; Amendment 39-13043; AD 2003-03-18] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2934. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a report entitled, ''Suspension of Limitations Under the Jerusalem Embassy Act'' (Presidential Determination No. 2003-26), pursuant to Public Law 104—45, section 6 (109 Stat. 400); jointly to the Committees on International Relations and Appropriations.

2935. A letter from the Associate Administrator, Office of Veterans Business Development, Small Business Administration, transmitting a letter regarding a report describing the activities of the Committee and any recommendations developed by the Committee for the promotion of small business concerns owned and controlled by veterans; jointly to the Committees on Small Business and Veterans' Affairs.

2936. A letter from the Railroad Retirement Board, transmitting a copy of the 22nd Actuarial Valuation of the Assets and Liabilities Under the Railroad Retirement Acts, pursuant to 45 U.S.C. 231f—1; jointly to the Committees on Ways and Means and Transportation and Infrastructure.

REPORTS OF COMMITTEE ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 438. A bill to increase the a mount of student loans that may be forgiven for teachers in mathematics, science, and special education; with an amendment (Rept. 108–182). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2211. A bill to reauthorize title II of the Higher Education Act of 1965; with an amendment (Rept. 108–183). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2210. A bill to reauthorize the Head Start Act to improve school readiness of disadvantaged children, and for other purposes; with an amendment (Rept. 108–184). Referred to the Committee of the Whole House on the State of the Union.

Mr. POMBO: Committee on Resources. H.R. 74. A bill to direct the Secretary of agriculture to convey certain land in the lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California (Rept. 108–185). Referred to the Committee of the Whole House and the State of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. CASE (for himself, Mr. SANDERS, Ms. BORDALLO, and Mr. FROST):

H.R. 2607. A bill to modify the contract consolidation requirements in the Small Business Act, and for other purposes; to the Committee on Small Business.

By Mr. SMITH of Michigan (for himself and Mr. BAIRD):

H.R. 2608. A bill to reauthorize the National Earthquake Hazards Reduction Program, and for other purposes; to the Committee on Science, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CONYERS:

H.R. 2609. A bill to amend title 11, United States Code, to provide for the avoidance of certain transfers, and the alternate prosecution of certain actions, relating to certain retirement benefits; to the Committee on the Judiciary.

By Mr. PETERSON of Minnesota (for himself, Mr. LATHAM, Mr. CRAMER, Mr. BOEHNER, Mr. HALL, Mr. SIMPSON, Mr. DOOLEY of California, Mr. GUTKNECHT, Mr. BOSWELL, Mr. JANKLOW, Mr. LUCAS of Kentucky, and Ms. HARRIS):

H.R. 2610. A bill to amend the Internal Revenue Code of 1986 to restore the estate tax and repeal the carryover basis rule, to increase the estate and gift tax unified credit to an exclusion equivalent of $5,000,000, and to reduce the rate of the estate and gifts taxes to the generally applicable capital gains income tax rate; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself, Mr. BROWN of South Carolina, Mr. EVANS, Mr. FILNER, Mr. GUTIERREZ, Ms. CORRINE BROWN of Florida, Mr. RODRIGUEZ, Mr. RYAN of Ohio, and Mr. FROST):

H.R. 2611. A bill to amend title II of the Social Security Act to exempt from the windfall elimination provision of such title individuals who are entitled to retired pay based on at least 20 years of service as a member of a uniformed service; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself and Mr. EVANS):

H.R. 2612. A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide specially adapted housing assistance to veterans with permanent and total service-connected disabilities due to the loss, or loss of use of both upper extremities such as to preclude use of the arms at and below the elbows; to the Committee on Veterans' Affairs.

By Mr. SABO (for himself, Ms. KAPTUR, and Mr. FROST):

H.R. 2613. A bill to amend title 17, United States Code, to exclude from copyright protection works resulting from scientific research substantially funded by the Federal Government; to the Committee on the Judiciary.

By Mr. MCGOVERN (for himself, Mr. SHAYS, and Mr. FERGUSON):

H.R. 2614. A bill to amend the Internal Revenue Code of 1986 to equalize the exclusion from gross income of parking and transportation fringe benefits and to provide for a common cost-of-living adjustment; to the Committee on Ways and Means.

By Mr. COSTELLO (for himself, Mr. DAVIS of Tennessee, Mr. OBERSTAR, Mr. RAHALL, Mr. FILNER, Mr. MENENDEZ, Mr. CUMMINGS, Mr. LIPINSKI, Mrs. TAUSCHER, Mr. BISHOP of New York, Mr. BLUMENAUER, Mr. EMANUEL, Mr. NADLER, Mr. CLAY, Mr. HOLDEN, Ms. NORTON, Mr. HONDA, Mr. CAPUANO, Mr. BAIRD, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. MICHAUD, Mr. LARSEN of Washington, Mr. WEINER, Mr. DEFAZIO, Ms. MILLENDER-MCDONALD, Ms. BERKLEY, Mr. PASCRELL, Mr. BOSWELL, Ms. CORRINE BROWN of Florida, Ms. CARSON of Indiana, Mr. THOMPSON of California, Mr. HOEFFEL, Mr. LAMPSON, Mr. MATHESON, and Mr. CARSON of Oklahoma):

H.R. 2615. A bill to provide funding for infrastructure investment to restore the United States economy and to enhance the security of transportation and environmental facilities throughout the United States; to the Committee on Transportation and Infrastructure, and in addition to the Committees on Ways and Means, Energy and Commerce, Financial Services, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FARR (for himself, Mr. WOLF, Mr. HOEFFEL, Mr. LEACH, and Mr. WEXLER):

H.R. 2616. A bill to increase the capabilities of the United States to provide reconstruction assistance to countries or regions impacted by armed conflict, and for other purposes; to the Committee on International Relations.

By Mr. SHADEGG:

H.R. 2617. A bill to protect American consumers from identity theft and other forms of fraud; to the Committee on Financial Services, and in addition to the Committees on Ways and Means, and Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. OBEY:

H.R. 2618. A bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; to the Committee on Appropriations.

By Mr. CASE:

H.R. 2619. A bill to provide for the expansion of Kilauea Point National Wildlife Refuge; to the Committee on Resources.

By Mr. SMITH of New Jersey (for himself, Mr. LANTOS, Mr. PITTS, Ms. SLAUGHTER, and Ms. ESHOO):

H.R. 2620. A bill to authorize appropriations for fiscal years 2004 and 2005 for the Trafficking Victims Protection Act of 2000, and for other purposes; to the Committee on International Relations, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ALLEN (for himself, Mr. SIMMONS, Mr. DELAHUNT, Mrs. CAPPS, Mr. CAPUANO, Mr. FARR, Mr. MARKEY, Mr. GEORGE MILLER of California, and Ms. WOOLSEY):

H.R. 2621. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fishing quota systems; to the Committee on Resources.

By Mr. BACHUS (for himself, Ms. HOOLEY of Oregon, Mrs. BIGGERT, Mr. MOORE, Mr. LATOURETTE, Mr. KANJORSKI, Mr. CASTLE, Mrs. MALONEY, Mr. SHADEGG, Mr. FORD, Mr. TIBERI, Mr. HINOJOSA, Mr. HENSARLING, Mr. CROWLEY, Mr. SESSIONS, Mr. ROSS, Mr. MATHESON, Mr. DAVIS of Alabama, Mr. BAKER, Mr. KING of New York, Mr. LUCAS of Oklahoma, Mr. LUCAS of Kentucky, Mr. NEY, Mrs. KELLY, Mr. JONES of North Carolina, Mr. ISRAEL, Ms. HART, Mr. MILLER of North Carolina, Mrs. CAPITO, Mrs. MCCARTHY of New York, Mr. BARRETT of South Carolina, Mr. FEENEY, and Ms. HARRIS):

H.R. 2622. A bill to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes; to the Committee on Financial Services.

By Mr. BACHUS:

H.R. 2623. A bill to provide for the expansion of the Cahaba River National Wildlife Refuge in Bibb County, Alabama; to the Committee on Resources.

By Mr. BOSWELL:

H.R. 2624. A bill to amend title XVIII of the Social Security Act to improve the provision of items and services provided to Medicare beneficiaries residing in rural areas; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WAXMAN (for himself, Mr. FROST, Mr. KIND, Mr. ACKERMAN, Ms. BERKLEY, Mr. CARSON of Oklahoma, Mr. DAVIS of Florida, Mr. DOOLEY of California, Mr. ENGEL, Mr. ETHERIDGE, Mr. FORD, Mr. HILL, Mr. ISRAEL, Mr. LYNCH, Mrs. MALONEY, Mr. MARKEY, Mr. MEEHAN, Mr. PASCRELL, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SHERMAN, Mrs. TAUSCHER, Mr. WEINER, and Mr. WEXLER):

H.R. 2625. A bill to establish the Independent Commission on Intelligence about Iraq; to the Committee on Intelligence (Permanent Select).

By Mr. UPTON (for himself and Mr. KIND):

H.R. 2626. A bill to amend the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1966 to improve certain child nutrition programs, and for other purposes; to the Committee on Education and the Workforce.

By Mr. BURTON of Indiana (for himself, Mr. PALLONE, and Mr. PAUL):

H.R. 2627. A bill to amend the Internal Revenue Code of 1986 to provide that amounts paid for foods for special dietary use, dietary supplements, or medical foods shall be treated as medical expenses; to the Committee on Ways and Means.

By Mr. CAPUANO (for himself, Mr. QUINN, Mr. ABERCROMBIE, Mr. REYES, Ms. LEE, Mr. GRIJALVA, Mr. LEWIS of Kentucky, Ms. SCHAKOWSKY, Mr. RANGEL, Mr. HINCHEY, Ms. MILLENDER-MCDONALD, Mr. OWENS, and Mr. LANTOS):

H.R. 2628. A bill to provide affordable housing opportunities for families that are headed by grandparents and other relatives of children; to the Committee on Financial Services.

By Mr. CROWLEY (for himself, Mr. SANDERS, Mr. CASE, Mr. HINCHEY, and Mrs. MALONEY):

H.R. 2629. A bill to provide for the importation of drugs into the United States from Canada and Mexico, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. JACKSON-LEE of Texas (for herself, Mr. CONYERS, Mr. GUTIERREZ, Mr. REYES, Mr. RODRIGUEZ, Mr. GREEN of Texas, Mr. GONZALEZ, Mr. LAMPSON, Mr. FROST, Mr. GRIJALVA, Ms. SOLIS, Mr. SANDLIN, Mr. BECERRA, Ms. WATSON, Mr. MEEK of Florida, Ms. EDDIE BERNICE JOHNSON of Texas, Ms. LEE, Mr. HINCHEY, Mr. MEEKS of New York, Mr. MENENDEZ, Mr. BACA, Mr. ORTIZ, Ms. VELAZQUEZ, Mrs. NAPOLITANO, Mr. HONDA, Mr. SERRANO, Mr. HINOJOSA, Mr. FARR, Mr. BERMAN, Ms. LORETTA SANCHEZ of California, Ms. LINDA T. SANCHEZ of California, Mr. LEWIS of Georgia, Ms. MILLENDER-MCDONALD, Mr. MEEHAN, and Ms. LOFGREN):

H.R. 2630. A bill to prevent commercial alien smuggling, and for other purposes; to the Committee on the Judiciary.

By Mr. TOM DAVIS of Virginia (for himself, Mr. WOLF, Mrs. JO ANN DAVIS of Virginia, and Mr. MORAN of Virginia):

H.R. 2631. A bill to provide that the actuarial value of the prescription drug benefits offered to Medicare eligible enrollees by a plan under the Federal employees health benefits program shall be at least equal to the actuarial value of the prescription drug benefits offered by such plan to its enrollees generally; to the Committee on Government Reform.

By Mr. DUNCAN:

H.R. 2632. A bill to direct the Secretary of Transportation to issue a regulation requiring the installation of 2 combination cockpit voice recorder and digital flight data recorder systems in each commercial passenger aircraft, currently required to carry each of those recorders, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. EMANUEL (for himself, Mr. OSE, Mr. FROST, Mr. SANDERS, Ms. HOOLEY of Oregon, Mr. OBERSTAR, Ms. DELAURO, Mr. BOUCHER, Mr. DAVIS of Alabama, Ms. CARSON of Indiana, Mr. DAVIS of Illinois, Mr. LANTOS, Mr. CARDOZA, Mr. TIERNEY, Mr. CASE, Mr. GRIJALVA, Mrs. MCCARTHY of New York, Ms. LINDA T. SANCHEZ of California, and Mr. SERRANO):

H.R. 2633. A bill to establish methods for preventing identity theft and to amend the Fair Credit Reporting Act to protect consumers' sensitive, private health-related information, and for other purposes; to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, the Judiciary, and Financial Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ENGLISH (for himself and Mr. HAYWORTH):

H.R. 2634. A bill to suspend temporarily the duty on certain steam generators and certain reactor vessel heads for use in nuclear reactors; to the Committee on Ways and Means.

By Mr. ENGLISH:

H.R. 2635. A bill to make permanent the reduction in capital gains rates for individuals made by the Jobs and Growth Tax Relief Reconciliation Act of 2003; to the Committee on Ways and Means.

By Mr. GREEN of Wisconsin (for himself, Mr. MCINNIS, and Mr. RYAN of Wisconsin):

H.R. 2636. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GUTIERREZ (for himself, Ms. DELAURO, Mr. ENGEL, Mr. FROST, Mr. KUCINICH, Ms. BORDALLO, Mr. GRIJALVA, Mr. MCDERMOTT, Ms. ESHOO, Ms. LEE, Mr. OWENS, Mr. LANTOS, Mr. SERRANO, and Mr. EMANUEL):

H.R. 2637. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions; to the Committee on Financial Services.

By Mr. HERGER:

H.R. 2638. A bill to amend the Internal Revenue Code of 1986 to make permanent the increase in expensing of certain depreciable business assets enacted by the Jobs and Growth Tax Relief Reconciliation Act 2003; to the Committee on Ways and Means.

By Ms. HOOLEY of Oregon:

H.R. 2639. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. KENNEDY of Rhode Island (for himself, Mr. FROST, and Ms. NORTON):

H.R. 2640. A bill to provide greater access to affordable pharmaceuticals, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GEORGE MILLER of California (for himself and Mrs. TAUSCHER):

H.R. 2641. A bill to authorize the Secretary of the Interior to implement the Calfed Bay-Delta Program; to the Committee on Resources, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. MYRICK:

H.R. 2642. A bill to suspend temporarily the duty on Procion Yellow H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2643. A bill to suspend temporarily the duty on Procion Crimson H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2644. A bill to suspend temporarily the duty on Procion Navy H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2645. A bill to suspend temporarily the duty on Dianix Black XF; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2646. A bill to suspend temporarily the duty on Dianix Crimson SF; to the Committee on Ways and Means.

By Ms. NORTON:

H.R. 2647. A bill to provide for nuclear disarmament and economic conversion in accordance with District of Columbia Initiative Measure Number 37 of 1992; to the Committee on Armed Services, and in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. POMBO:

H.R. 2648. A bill to amend the Internal Revenue Code of 1986 to permit the use of proceeds of tax exempt private activity bonds for community and water facility loans guaranteed under the Consolidated Farm and Rural Development Act; to the Committee on Ways and Means.

By Mr. PORTER (for himself, Mr. CARTER, and Mr. COLE):

H.R. 2649. A bill to prohibit the Secretary of Education from making any funds available to a State under any program administered by the Department of Education unless the Secretary determines that the State has in place a criminal information sharing system; to the Committee on Education and the Workforce.

By Mr. RAHALL (for himself, Ms. PELOSI, Mr. UDALL of New Mexico, Mr. RODRIGUEZ, and Mr. HOYER):

H.R. 2650. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service; to the Committee on Resources.

By Ms. LINDA T. SANCHEZ of California (for herself, Mr. GEORGE MILLER of California, Mr. TOWNS, Mr. RUSH, Ms. MILLENDER-MCDONALD, Mr. FROST, Mr. GRIJALVA, Mr. PASTOR, Mr. ORTIZ, Mr. REYES, Mr. HINOJOSA, Mr. BACA, Ms. JACKSON-LEE of Texas, Mr. MCGOVERN, Mr. SERRANO, Mr. ETHERIDGE, Mr. ENGEL, Mr. MCDERMOTT, Mr. NADLER, Mrs. DAVIS of California, and Ms. DELAURO):

H.R. 2651. A bill to direct the Secretary of Education to make grants to States to establish antibullying programs; to the Committee on Education and the Workforce.

By Mr. STUPAK:

H.R. 2652. A bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the sale of prescription drugs through the Internet; to the Committee on Energy and Commerce.

By Mr. UDALL of Colorado:

H.R. 2653. A bill to facilitate acquisition by the Secretary of the Interior of certain mineral rights, and for other purposes; to the Committee on Resources.

By Mr. VITTER:

H.R. 2654. A bill to amend the Outer Continental Shelf Lands Act to direct the Secretary of the Interior to issue regulations under which the Secretary may authorize use of a decommissioned offshore oil and gas platform for culture of marine organisms, an artificial reef, or scientific research, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WALSH (for himself, Mr. KING of New York, Mr. NEAL of Massachusetts, Mr. CROWLEY, Mr. SWEENEY, Mr. MCDERMOTT, Mrs. MCCARTHY of New York, Mr. DOYLE, Mr. QUINN, Mr. MOLLOHAN, Mr. HOLDEN, Mr. SMITH of New Jersey, Mr. ACKERMAN, Mr. MCNULTY, Mr. ENGEL, Mr. PAYNE, Mr. FROST, and Mr. DUNCAN):

H.R. 2655. A bill to amend and extend the Irish Peace Process Cultural and Training Program Act of 1998; to the Committee on the Judiciary, and in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. WOOLSEY (for herself and Mr. THOMPSON of California):

H.R. 2656. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Resources.

By Mr. KING of New York (for himself, Mr. WALSH, Mr. NEAL of Massachusetts, Mr. CROWLEY, Mr. SWEENEY, Mr. SMITH of New Jersey, Mr. DELAHUNT, Mr. QUINN, Mr. CAPUANO, Mr. ACKERMAN, Mr. ENGEL, Mr. EVANS, Mr. FOSSELLA, Mr. HOLDEN, Mrs. MALONEY, Mr. MCNULTY, Mr. OWENS, Mr. SOUDER, and Mr. WEINER):

H.J. Res. 62. A joint resolution recognizing Commodore John Barry as the first flag officer of the United States Navy; to the Committee on Armed Services.

By Mr. DELAY:

H. Con. Res. 231. Concurrent resolution providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate; considered and agreed to.

By Mr. ANDREWS (for himself, Mr. SESSIONS, Mr. HEFLEY, Mr. SOUDER, Mr. PENCE, Mr. BURTON of Indiana, and Mr. WU):

H. Con. Res. 232. Concurrent resolution expressing the sense of Congress regarding security for Taiwan; to the Committee on International Relations.

By Mr. FOSSELLA (for himself and Mr. TOWNS):

H. Con. Res. 233. Concurrent resolution expressing the sense of Congress regarding the dire humanitarian situation in Liberia and efforts to introduce peace and justice to that country; to the Committee on International Relations.

By Ms. KILPATRICK (for herself, Mrs. CHRISTENSEN, Mr. SERRANO, Mr. STARK, Mr. OWENS, Mr. HOEFFEL, Mr. DAVIS of Illinois, Ms. CARSON of Indiana, Mr. WAXMAN, Ms. LEE, Mrs. JONES of Ohio, Ms. NORTON, and Mr. KILDEE):

H. Con. Res. 234. Concurrent resolution recognizing the importance of preserving the survival of essential urban hospitals; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PASCRELL (for himself, Mr. OXLEY, Mr. BROWN of Ohio, Mr. CLAY, Mr. ETHERIDGE, Mr. FERGUSON, Mr. FORD, Mr. FROST, Mr. HOLT, Mr. JEFFERSON, Mr. KUCINICH, Mr. PAYNE, Mr. TOWNS, Mr. GRIJALVA, Mr. MCDERMOTT, Mrs. CHRISTENSEN, Mr. PALLONE, Mr. SABO, Mr. KING of New York, Mr. FRANK of Massachusetts, Ms. KAPTUR, Mr. ACEVEDO-VILA, Mr. NEAL of Massachusetts, Mr. DOYLE, Mr. CAPUANO, and Mr. BRADY of Pennsylvania):

H. Con. Res. 235. Concurrent resolution celebrating the life and achievements of Lawrence Eugene ''Larry'' Doby; to the Committee on Government Reform.

By Mr. POMEROY:

H. Con. Res. 236. Concurrent resolution permitting the use of the rotunda of the Capitol for a ceremony to commemorate the unveiling of the statue of Sakakawea provided by the State of North Dakota for display in Statuary Hall; to the Committee on House Administration.

By Mr. RENZI (for himself, Mr. FRANKS of Arizona, and Mr. GRIJALVA):

H. Con. Res. 237. Concurrent resolution honoring the late Rick Lupe, lead forestry technician for the Bureau of Indian Affairs Fort Apache Agency, for his dedication and service to the United States and for his essential service in fighting wildfires and protecting the environment and communities of Arizona; to the Committee on Resources.

By Mr. ROHRABACHER:

H. Con. Res. 238. Concurrent resolution supporting efforts to advance regional and community based water and sanitation needs of Israelis, Palestinians, and Jordanians as an effective bridge for peace building in the Middle East; to the Committee on International Relations.

By Ms. WATSON (for herself, Mr. LANTOS, and Mr. PAYNE):

H. Con. Res. 239. Concurrent resolution expressing the sense of the Congress that the global diamond industry, as represented by the World Diamond Council, should provide transition development assistance to communities in Sierra Leone, Angola, and the Democratic Republic of Congo, where the illicit trade in conflict diamonds for arms fueled civil war, and for other purposes; to the Committee on International Relations.

By Mr. HOEKSTRA:

H. Res. 300. A resolution recognizing the outstanding contributions of the faculty, staff, students, and alumni of Christian colleges and universities; to the Committee on Education and the Workforce.

By Mr. ABERCROMBIE:

H. Res. 301. A resolution expressing the sense of the House of Representatives that the Federal Government should actively pursue a unified approach to strengthen and promote the national policy on aquaculture; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FILNER (for himself, Mr. TOWNS, Mr. COOPER, Mrs. TAUSCHER, Mr. MCGOVERN, Mr. ABERCROMBIE, Mr. PALLONE, Mr. KIRK, and Mr. KUCINICH):

H. Res. 302. A resolution calling for the immediate and unconditional release from prison of certain Kurdish members of the Parliament of the Republic of Turkey; to the Committee on International Relations.

By Mr. LEWIS of Georgia (for himself, Mr. SCOTT of Georgia, Mr. MARSHALL, Mr. BISHOP of Georgia, Ms. MAJETTE, Mr. ISAKSON, Mr. LINDER, Mr. NORWOOD, Mr. KINGSTON, Mr. BURNS, Mr. GINGREY, Mr. COLLINS, Mr. DEAL of Georgia, Mr. FORD, Ms. LEE, Mr. DAVIS of Illinois, Mr. BALLANCE, Mrs. JONES of Ohio, Mr. WATT, Ms. CORRINE BROWN of Florida, Mr. RUSH, Mr. SCOTT of Virginia, Mr. OWENS, Mr. JEFFERSON, Mr. CLAY, Mr. RANGEL, Mr. MEEK of Florida, Mr. CUMMINGS, Ms. WATERS, Ms. JACKSON-LEE of Texas, Mrs. CHRISTENSEN, Mr. PAYNE, Ms. MILLENDER-MCDONALD, and Mr. THOMPSON of Mississippi):

H. Res. 303. A resolution honoring Maynard Holbrook Jackson, Jr., former Mayor of the City of Atlanta, and extending the condolences of the House of Representatives on his death; to the Committee on Government Reform.

By Mrs. NORTHUP:

H. Res. 304. A resolution expressing the sense of the House of Representatives regarding United States citizens adopting children from the People's Republic of China; to the Committee on the Judiciary.

By Mr. ROTHMAN (for himself, Mr. GARRETT of New Jersey, Mr. ANDREWS, Mr. LOBIONDO, Mr. PASCRELL, Mr. FERGUSON, Mr. PALLONE, Mr. SAXTON, Mr. PAYNE, Mr. FRELINGHUYSEN, Mr. HOLT, Mr. SMITH of New Jersey, and Mr. MENENDEZ):

H. Res. 305. A resolution congratulating the New Jersey Devils for winning the 2003 Stanley Cup championship; to the Committee on Government Reform.

By Mr. SERRANO (for himself and Mr. NEY):

H. Res. 306. A resolution congratulating the New York Yankees on the occasion of their 100th anniversary; to the Committee on Government Reform.

By Mrs. TAUSCHER (for herself, Mr. TAYLOR of Mississippi, Mr. WAXMAN, Mr. SPRATT, Mr. ALLEN, Mr. COOPER, Mr. SKELTON, Mr. FROST, Mr. SCHIFF, and Mr. DOOLEY of California):

H. Res. 307. A resolution creating a select committee to investigate the effectiveness of the United States' intelligence structure to meet global threats; to the Committee on Rules.

MEMORIALS

Under clause 3 of rule XII:

134. The SPEAKER presented a memorial of the Senate of the State of Hawaii, relative to Senate Resolution No. 36 memorializing the United States Congress to appropriate adequate financial impact assistance for health, education, and other social services for Hawaii's Freely Associated States citizens; jointly to the Committees on Agriculture, Financial Services, Ways and Means, and Energy and Commerce.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 22: Mr. WAMP.
H.R. 91: Mr. NEUGEBAUER.
H.R. 193: Mr. BOOZMAN.
H.R. 218: Mr. KILDEE and Mr. HOEKSTRA.
H.R. 236: Mr. ROSS, Mr. RUPPERSBERGER, and Mr. SCOTT of Georgia.
H.R. 276: Mr. HASTINGS of Washington.
H.R. 284: Mrs. MILLER of Michigan, Mr. YOUNG of Alaska, Mr. DICKS, Mr. BOOZMAN, and Mr. LEWIS of Georgia.
H.R. 290: Mr. WHITFIELD, Mr. WYNN, Mr. OWENS, and Mr. UPTON.
H.R. 339: Mr. ROGERS of Michigan.
H.R. 384: Mr. GOODE.
H.R. 401: Mr. MURPHY.
H.R. 438: Mr. BRADLEY of New Hampshire and Ms. EDDIE BERNICE JOHNSON of Texas.
H.R. 465: Mr. LEWIS of Kentucky and Mr. MANZULLO.
H.R. 466: Mr. JANKLOW.
H.R. 505: Mrs. WILSON of New Mexico.
H.R. 528: Mr. RAMSTAD and Mr. FERGUSON.
H.R. 577: Mr. DINGELL and Mr. BALLANCE.
H.R. 594: Mr. BISHOP of Utah, Mr. PETERSON of Minnesota, and Mr. MCDERMOTT.
H.R. 643: Mr. EVANS.
H.R. 648: Mr. BOOZMAN.
H.R. 668: Ms. WATSON.
H.R. 716: Mr. SADLIN.
H.R. 745: Mr. GEPHARDT.
H.R. 806: Mrs. NORTHUP, Mr. KINGSTON, Ms. LEE, Mr. RANGEL, Mr. UPTON, and Mr. OLVER.
H.R. 812: Mr. SESSIONS.
H.R. 817: Mr. NORWOOD.
H.R. 834: Ms. MCCARTHY of Missouri, Mr. ISTOOK, Ms. JACKSON-LEE of Texas, Mr. LUCAS of Oklahoma, and Mr. OWENS.
H.R. 839: Mr. GERLACH, Mr. RYAN of Ohio, Mr. TOWNS, Mr. LAMPSON, Mr. POMBO, Mr. PASCRELL, Mr. EMANUEL, Mrs. MALONEY, Mr. JEFFERSON, Mr. STUPAK, and Mr. KANJORSKI.
H.R. 876: Mr. KENNEDY of Minnesota.
H.R. 898: Ms. MILLENDER-MCDONALD, Mr. SERRANO, Mr. WAXMAN, Mr. OSBORNE, Mr. CONYERS, Mrs. KELLY, Mr. GARRETT of New Jersey, Mr. CLYBURN, and Mr. MARSHALL.
H.R. 918: Mr. OBERSTAR, Mr. LAHOOD, Mr. MEEHAN, Mr. ROGERS of Michigan, Mr. STUPAK, Mr. PASCRELL, Mr. HOLT, Ms. MCCOLLUM, Ms. BALDWIN, and Mr. PAYNE.
H.R. 919: Mr. SHAW.
H.R. 970: Mr. SPRATT, Mr. GREEN of Wisconsin, Ms. DELAURO, and Mr. ROGERS of Michigan.
H.R. 980: Mr. HINCHEY, Mr. FILNER, and Mr. TIERNEY.
H.R. 990: Mr. BISHOP of Utah, Mr. BURGESS, Mr. BARTLETT of Maryland, Mrs. CUBIN, Mr. COLLINS, Mr. DEMINT, Mr. SANDLIN, Mr. CARTER, Mr. ROGERS of Kentucky, Mr. KELLER, and Mr. FOLEY.
H.R. 996: Mr. PORTMAN and Mr. TIAHRT.
H.R. 997: Mr. MILLER of Florida.
H.R. 1006: Mr. KUCINICH and Ms. LINDA T. SANCHEZ of California.
H.R. 1008: Mr. LATHAM and Mr. BEAUPREZ.
H.R. 1046: Mr. MCDERMOTT.
H.R. 1049: Mr. FRANKS of Arizona.
H.R. 1059: Mr. MCGOVERN.
H.R. 1066: Mr. CANNON.
H.R. 1068: Mr. SMITH of New Jersey, Mr. UDALL of New Mexico, Mr. MURPHY, Mr. SCHROCK, Mr. ISRAEL, and Mr. TOOMEY.
H.R. 1088: Ms. ROS-LEHTINEN and Mr. OWENS.
H.R. 1097: Mr. LARSON of Connecticut and Mr. OWENS.
H.R. 1102: Mr. POMEROY.
H.R. 1117: Mr. BARTON of Texas.
H.R. 1157: Mr. OBERSTAR, Mr. CUMMINGS, and Mrs. DAVIS of California.
H.R. 1169: Mr. JANKLOW.
H.R. 1196: Mr. WU.
H.R. 1207: Mr. CLYBURN.
H.R. 1220: Mr. ISSA.
H.R. 1231: Mr. CLYBURN, Mr. SMITH of Texas, Mrs. MUSGRAVE, Mr. MEEK of Florida, Mr. LAMPSON, Mr. PETERSON of Minnesota, Mr. GOSS, and Mr. QUINN.
H.R. 1244: Ms. CORRINE BROWN of Florida, Mr. MCGOVERN, and Ms. BERKLEY.
H.R. 1260: Mr. THORNBERRY.
H.R. 1268: Mr. CLYBURN and Mr. DEUTSCH.
H.R. 1279: Mr. KILDEE.
H.R. 1288: Mrs. MUSGRAVE and Mr. EMANUEL.
H.R. 1301: Ms. LOFGREN, Mr. GERLACH, Mr. LYNCH, and Mr. GOODE.
H.R. 1310: Mr. SESSIONS.
H.R. 1347: Mr. MCGOVERN, Mr. OWENS, and Mr. FROST.
H.R. 1372: Mr. SAM JOHNSON of Texas, Mr. HENSARLING, Mr. BELL, Mr. ROHRABACHER, and Mr. MEEHAN.
H.R. 1385: Mr. OBERSTAR, Mr. MATHESON, Mr. ENGLISH, and Ms. VELAZQUEZ.
H.R. 1400: Mr. BLUMENAUER.
H.R. 1414: Mr. DEFAZIO.
H.R. 1429: Mr. EVANS.
H.R. 1461: Mr. ROTHMAN.
H.R. 1466: Mr. GORDON.
H.R. 1477: Mr. ANDREWS.
H.R. 1482: Mr. OWENS.
H.R. 1499: Mr. OWENS.
H.R. 1501: Mrs. NAPOLITANO.
H.R. 1532: Ms. SLAUGHTER, Ms. HARMAN, Mr. FILNER, Mr. ALLEN, and Mr. DICKS.
H.R. 1563: Mr. WEXLER.
H.R. 1582: Mr. JANKLOW, Mr. HENSARLING, Mr. WU, Mr. GONZALEZ, and Mr. KING of Iowa.
H.R. 1592: Mrs. DAVIS of California.
H.R. 1611: Ms. DELAURO.
H.R. 1622: Mr. DEMINT, Mr. BOOZMAN, and Mr. BONILLA.
H.R. 1639: Mr. MORAN of Virginia, Mr. WEXLER, and Mr. GREEN of Texas.
H.R. 1641: Mr. BLUMENAUER.
H.R. 1675: Mr. HASTINGS of Washington.
H.R. 1684: Mr. VAN HOLLEN, Ms. DEGETTE, Mr. MOORE, Mr. CROWLEY, Mr. FARR, Mr. MORAN of Virginia, Ms. CARSON of Indiana, Mr. ENGEL, Mr. TIERNEY, Mr. RANGEL, Mr. MEEKS of New York, Ms. ESHOO, Mr. SCHIFF, Mr. MCDERMOTT, Mr. BELL, Ms. NORTON, Mr. WEXLER, Mr. FILNER, Mr. HOLT, Mr. SERRANO, Mrs. NAPOLITANO, Mr. FRANK of Massachusetts, Mr. PRICE of North Carolina, and Mr. BLUMENAUER.
H.R. 1690: Mr. FILNER.
H.R. 1707: Mr. SOUDER, Mr. ADERHOLT, Mr. FORBES, Mrs. JO ANN DAVIS of Virginia, and Mr. CLYBURN.
H.R. 1749: Mr. PUTNAM, Mr. LEWIS of Kentucky, Mr. FROST, and Mrs. CHRISTENSEN.
H.R. 1767: Mr. HASTINGS of Washington, Mr. TOOMEY, Mr. BILIRAKIS, Mr. MORAN of Virginia, and Mr. NETHERCUTT.
H.R. 1769: Mr. THOMPSON of California and Ms. LINDA T. SANCHEZ of California.
H.R. 1771: Mr. CALVERT.
H.R. 1776: Mr. EMANUEL.
H.R. 1792: Mr. FROST, Mr. RODRIGUEZ, Ms. BORDALLO, Mr. SANDERS, Mr. WILSON of South Carolina, Mr. SOUDER, Mr. TOWNS, Mr. GRIJALVA, and Mr. OWENS.
H.R. 1819: Mr. LEACH and Mr. FLETCHER.
H.R. 1824: Mr. DICKS, Mr. ROTHMAN, Mr. BRADY of Pennsylvania, Mr. BAIRD, and Mr. PASCRELL.
H.R. 1828: Ms. NORTON, Mr. BECERRA, Mr. UDALL of New Mexico, Mr. COOPER, Mr. MENENDEZ, Mr. FRELINGHUYSEN, Mr. LOBIONDO, Mr. FLETCHER, Mrs. CAPITO, and Mr. CASTLE.
H.R. 1829: Mr. PLATTS and Mr. MEEHAN.
H.R. 1865: Mr. LEACH.
H.R. 1867: Mr. PAUL and Mr. DUNCAN.
H.R. 1874: Mr. ENGEL and Mr. KUCINICH.
H.R. 1886: Ms. VELAZQUEZ and Mr. DAVIS of Tennessee.
H.R. 1918: Mr. MURPHY.
H.R. 1919: Mr. MCGOVERN, Mr. GRIJALVA, and Ms. CARSON of Indiana.
H.R. 1920: Mr. MCGOVERN, Mr. OWENS, and Mrs. CHRISTENSEN.
H.R. 1921: Mr. MCGOVERN and Mr. OWENS.
H.R. 1924: Mr. MCGOVERN, Mr. OWENS, Mr. FROST, and Mr. MCINTYRE.
H.R. 1997: Mr. RAHALL and Mr. LUCAS of Oklahoma.
H.R. 2008: Mrs. CHRISTENSEN.
H.R. 2009: Mr. MCGOVERN and Mr. SIMMONS.
H.R. 2011: Mr. DEUTSCH, Ms. WATERS, Mr. HAYES, Mr. MCHUGH, Mr. PASTOR, and Ms. MCCOLLUM.
H.R. 2042: Ms. LEE, Mr. PAYNE, Ms. MCCARTHY of Missouri, Mr. INSLEE, Ms. BALDWIN, Mrs. NAPOLITANO, Ms. SLAUGHTER, Mr. CASE, Mrs. TAUSCHER, Ms. CARSON of Indiana, Mr. DELAHUNT, and Mr. ISRAEL.
H.R. 2047: Mr. POMEROY.
H.R. 2053: Mr. ABERCROMBIE and Mr. GRIJALVA.
H.R. 2075: Mr. GOSS, Mr. FOLEY, Ms. ROS-LEHTINEN, and Mr. CRENSHAW.
H.R. 2090: Mr. KUCINICH.
H.R. 2096: Mr. GREEN of Texas, Mr. FOLEY, Mr. COLLINS, Mr. SIMMONS, Mr. SKELTON, Ms. VELAZQUEZ, Mr. SMITH of New Jersey, and Mr. MORAN of Virginia.
H.R. 2125: Mr. STUPAK.
H.R. 2154: Mr. LIPINSKI.

H.R. 2172: Mr. GILLMOR, Mr. MCGOVERN, and Mr. CAMP.
H.R. 2178: Mr. RAMSTAD.
H.R. 2180: Mrs. BIGGERT.
H.R. 2193: Mr. ACKERMAN and Mrs. MCCARTHY of New York.
H.R. 2203: Mr. OWENS.
H.R. 2220: Mr. BRADY of Texas.
H.R. 2237: Mrs. JONES of Ohio and Mr. NEY.
H.R. 2249: Mr. OSBORNE.
H.R. 2309: Mr. MCKEON, Mr. DREIER, Mr. HERGER, Mr. OSE, Mr. DOOLITTLE, Mr. POMBO, Mr. RADANOVICH, Mr. NUNES, Mr. THOMAS, Mr. GALLEGLY, Mr. ROYCE, Mr. LEWIS of California, Mr. GARY G. MILLER of California, Mr. CALVERT, Mrs. BONO, Mr. ROHRABACHER, Mr. COX, Mr. ISSA, Mr. CUNNINGHAM, Mr. HUNTER, Mr. THOMPSON of California, and Ms. ROYBAL-ALLARD.
H.R. 2314: Mr. CASE, Mr. KENNEDY of Rhode Island, Mr. MCINTYRE, and Mr. BROWN of Ohio.
H.R. 2327: Mrs. CAPITO.
H.R. 2333: Mr. REHBERG.
H.R. 2340: Mr. BURR and Mr. KOLBE.
H.R. 2357: Mrs. JO ANN DAVIS of Virginia.
H.R. 2379: Mr. PAUL.
H.R. 2386: Mrs. CUBIN, Mr. REHBERG, Mr. BISHOP of Utah, and Mr. HAYWORTH.
H.R. 2393: Mr. OWENS.
H.R. 2419: Mr. BLUMENAUER.
H.R. 2433: Mr. GUTIERREZ, Mr. MICHAUD, and Mr. SNYDER.
H.R. 2435: Mr. NADLER, Mr. THOMPSON of California, and Mr. DAVIS of Florida.
H.R. 2441: Mrs. MCCARTHY of New York, Mrs. NAPOLITANO, Mr. SHIMKUS, Ms. MCCOLLUM, Mr. CALVERT, Mr. PLATTS, Mr. LARSON of Connecticut, and Mr. SCHIFF.
H.R. 2455: Mr. BERMAN.
H.R. 2462: Mr. CLAY and Mr. OBEY.
H.R. 2470: Mr. CROWLEY, Mr. PAYNE, Mr. MCNULTY, Mr. CONYERS, Mrs. CHRISTENSEN, and Mr. EVANS.
H.R. 2478: Mr. MCDERMOTT, Mr. LANTOS, and Mr. OWENS.
H.R. 2485: Mr. KUCINICH.
H.R. 2505: Mr. OWENS.
H.R. 2517: Mr. COBLE.
H.R. 2519: Mr. SABO, Mr. SIMMONS, Mr. KLECZKA, and Mr. GILCHREST.
H.R. 2524: Mr. WAXMAN and Mr. SANDERS.
H.R. 2533: Mr. LINDER, Mr. ISAKSON, and Mr. SCOTT of Georgia.
H.R. 2537: Mr. OWENS.
H.R. 2546: Ms. LEE.
H.R. 2553: Ms. LOFGREN, Mr. ABERCROMBIE, Mr. RANGEL, and Mr. ROSS.
H.R. 2556: Mr. COX, Mr. TERRY, and Mr. SOUDER.
H.R. 2564: Mr. MCGOVERN.
H.R. 2568: Mr. GORDON and Ms. DEGETTE.
H.R. 2570: Mr. WU and Mr. CLYBURN.
H.R. 2595: Mr. ABERCROMBIE, Mr. CASE, and Ms. BORDALLO.
H.J. Res. 9: Mr. BARRETT of South Carolina.
H.J. Res. 36: Mr. SPRATT.
H.J. Res. 59: Mr. LAHOOD.
H. Con. Res. 19: Mr. DINGELL and Mr. BALLANCE.
H. Con. Res. 60: Mr. BEAUPREZ, Mr. DEMINT, and Mr. ROHRABACHER.
H. Con. Res. 78: Ms. ESHOO.
H. Con. Res. 98: Ms. BORDALLO, Mr. SCOTT of Georgia, and Mr. AKIN.
H. Con. Res. 99: Ms. EDDIE BERNICE JOHNSON of Texas.
H. Con. Res. 111: Ms. EDDIE BERNICE JOHNSON of Texas and Mr. ISSA.
H. Con. Res. 119: Mr. SHIMKUS, Mrs. TAUSCHER, and Mr. BERMAN.
H. Res. 49: Mr. SCHIFF.
H. Res. 103: Mr. SANDERS.
H. Res. 142: Mr. NADLER and Mr. GUTIERREZ.
H. Res. 234: Mr. CARSON of Oklahoma and Mr. WATT.
H. Res. 237: Ms. MAJETTE.
H. Res. 259: Mr. MCGOVERN and Mr. ACKERMAN.
H. Res. 285: Mr. MCNULTY, Mr. WAXMAN, and Mr. BURR.
H. Res. 290: Ms. Slaughter.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:

H.R. 2407: Mr. MICHAUD.

DISCHARGE PETITIONS

Under clause of rule XV, the following discharge petition was filed:

Petition 3. June 25, 2003, by Mr. GENE TAYLOR on House Resolution 275, was signed by the following Members: Gene Taylor, Jane Harman, John S. Tanner, Charles W. Stenholm, Ed Case, and Leonard L. Boswell.

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:

Petition 2 by Mr. JIM MARSHALL on House Resolution 251: Michael E. Capuano, Carolyn C. Kilpatrick, Luis V. Gutierrez, Norman D. Dicks, Martin Olav Sabo, William O. Lipinski, David R. Obey, Richard A. Gephardt, Richard E. Neal, and John M. Spratt, Jr.

United States of America

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PROCEEDINGS AND DEBATES OF THE 108th CONGRESS, FIRST SESSION

Vol. 149 WASHINGTON, THURSDAY, JUNE 26, 2003 No. 96—Part II

Senate

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENTS NOS. 1014, 1015, 1059, 1106, 1086, 1067, 1033, 935, 959, 1038, 1095, EN BLOC

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside and that the following amendments be called up en bloc: No. 1014, by Senator BOND, study of pharmacy services; No. 1015, by Senator DODD, study of blind and disabled; No. 1059, by Senator HATCH, HHS review; No. 1106, by Senator HATCH, citizens councils; No. 1086, by Senator MURKOWSKI, pharmacy access; No. 1067, by Senator LINCOLN, kidney disease; No. 1033, by Senator MIKULSKI, municipal health services; No. 935, by Senator LINCOLN, geriatric GME; No. 959, by Senator LINCOLN, physical therapy demo; No. 1038, by Senator JEFFORDS, critical access hospital; No. 1095, by Senator JOHNSON, therapy management.

I further ask unanimous consent that these amendments be agreed to en bloc and the motion to reconsider be laid upon the table en bloc.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendments were agreed to.

VOTE ON AMENDMENT NO. 1011

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to the Sessions amendment No. 1011.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the following two votes be 10-minute votes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER (Mr. CORNYN). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 33, nays 65, as follows:

[Rollcall Vote No. 256 Leg.]

YEAS—33

Allard	Dole	Lott
Allen	Ensign	McConnell
Bennett	Enzi	Murkowski
Bunning	Frist	Nickles
Burns	Graham (SC)	Santorum
Byrd	Gregg	Sessions
Campbell	Hagel	Shelby
Chambliss	Hatch	Stevens
Cornyn	Hutchison	Sununu
Craig	Inhofe	Talent
Crapo	Kyl	Thomas

NAYS—65

Akaka	Dodd	Lugar
Alexander	Domenici	McCain
Baucus	Dorgan	Mikulski
Bayh	Durbin	Miller
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Bond	Feinstein	Nelson (NE)
Boxer	Fitzgerald	Pryor
Breaux	Graham (FL)	Reed
Brownback	Grassley	Reid
Cantwell	Harkin	Roberts
Carper	Hollings	Rockefeller
Chafee	Inouye	Sarbanes
Clinton	Jeffords	Schumer
Cochran	Johnson	Smith
Coleman	Kennedy	Snowe
Collins	Kohl	Specter
Conrad	Landrieu	Stabenow
Corzine	Lautenberg	Voinovich
Daschle	Leahy	Warner
Dayton	Levin	Wyden
DeWine	Lincoln	

NOT VOTING—2

Kerry	Lieberman

The amendment (No. 1011) was rejected.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. GRAHAM of Florida. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT 975, AS MODIFIED

The PRESIDING OFFICER. There are now 2 minutes evenly divided prior to the next vote.

Mr. ROCKEFELLER. Mr. President, this next amendment has to do with dual eligibility. Never in the history of Medicare have we precluded Medicare beneficiaries from being Medicare beneficiaries. In the underlying bill, for the very first time, we do.

The people I refer to are called dual eligibles. Their average income is $6,500 a year. They tend to be over 85, single women, and very sick. They are on Medicaid. Medicaid, however, is optional according to the States. We know the States to be broke. The fastest growing expense they face is Medicaid. So they are cutting the benefits. They are cutting Medicaid. They will continue to do that. The States have no choice but to cut Medicaid. Some will do it because they wish to, all will do it because they have to.

When that possibility is gone, there is no place for these poorest of the poor to go. They are then, under the underlying bill, precluded from being Medicare beneficiaries. That is wrong. In my budget-neutral amendment I attempt to fix it. I hope my colleagues will support the amendment.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Two things for my colleagues to consider during the consideration of how to vote on this amendment: No. 1 is the money that is available to pay for his amendment, an offset, is the very same amount of money we, Senator BAUCUS and I, are using to offset the cost of a lot of demonstration projects that colleagues have asked us to do, a lot of minor amendments they have asked us to do. If that money is not there, there cannot be consideration given. That is not a threat; it is just a practical aspect of how the budget law works.

Secondly, remember, these dual eligibles are being taken care of very well

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

in our underlying legislation. The point being, they will not be taken care of better. It is just it is going to cost the Federal Government more.

I hope you will take those things into consideration and vote down this amendment.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to amendment No. 975, as modified. The clerk will call the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 47, nays 51, as follows:

[Rollcall Vote No. 257 Leg.]

YEAS—47

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Pryor
Byrd	Graham (FL)	Reed
Cantwell	Harkin	Reid
Carper	Hollings	Rockefeller
Clinton	Inouye	Sarbanes
Collins	Johnson	Schumer
Conrad	Kennedy	Snowe
Corzine	Kohl	Specter
Daschle	Landrieu	Stabenow
Dayton	Lautenberg	Voinovich
DeWine	Leahy	Wyden
Dodd	Levin	

NAYS—51

Alexander	Crapo	Lugar
Allard	Dole	McCain
Allen	Domenici	McConnell
Baucus	Ensign	Miller
Bennett	Enzi	Murkowski
Bond	Fitzgerald	Nelson (NE)
Breaux	Frist	Nickles
Brownback	Graham (SC)	Roberts
Bunning	Grassley	Santorum
Burns	Gregg	Sessions
Campbell	Hagel	Shelby
Chafee	Hatch	Smith
Chambliss	Hutchison	Stevens
Cochran	Inhofe	Sununu
Coleman	Jeffords	Talent
Cornyn	Kyl	Thomas
Craig	Lott	Warner

NOT VOTING—2

Kerry	Lieberman

The amendment (No. 975), as modified, was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. CRAIG. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1066

The PRESIDING OFFICER. There are now 2 minutes equally divided on the Bingaman amendment.

Mr. BINGAMAN. Mr. President, the bill before us has, in my view, a significant flaw in it. We are holding out this prescription drug benefit. But the bill we are considering here says if you want to take advantage of the benefit, you are thereby prohibited from buying any supplemental insurance to cover prescription drugs. Today, people are able to buy Medigap policies that cover prescription drugs. In the future they will not be able to, if this bill becomes law as it is.

My amendment would merely give people the option of buying a prescription drug supplemental policy if they chose to do so. It directs that two policies be developed that would accomplish that.

It is supported by the insurance industry. It is supported by the Consumers Union. Seniors would like to have this opportunity to reduce their risk of substantial out-of-pocket costs.

We ought to provide this benefit.

Mr. GRASSLEY. Mr. President, first of all, let me make very clear that we know that Medigap is very important as part of Medicare. We leave that untouched as it relates to 1965 model Medicare. In fact, many of my Iowa constituents want to keep that. But we as a policy matter have made it a very conscious choice to prevent the sale of wraparound Medigap plans for the new Part D drug benefit. This policy makes sense considering drug plans could be different everywhere else in the United States.

It is impossible to standardize Medigap policies like we did about 15 years ago so that seniors don't get ripped off. But the Congressional Budget Office tells us this new Medigap plan that is before us now will increase the cost of our bill. The cost of this amendment is $1.5 billion over 10 years, according to the Congressional Budget Office. That is because of the increased utilization that comes from having additional insurance.

I share the Senator's concern with gaps in coverage. I wish we didn't have any.

But we believe participating drug plans—especially drug plans delivered by PPOs—will offer benefits in a comprehensive fashion, lessening the need for expensive supplemental policies.

I urge my colleagues to reject this amendment.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER (Mr. CHAMBLISS). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 43, nays 55, as follows:

[Rollcall Vote No. 258 Leg.]

YEAS—43

Akaka	Dorgan	Levin
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Nelson (NE)
Byrd	Graham (FL)	Pryor
Cantwell	Harkin	Reed
Carper	Hollings	Reid
Clinton	Inouye	Rockefeller
Collins	Johnson	Sarbanes
Conrad	Kennedy	Schumer
Corzine	Kohl	Stabenow
Daschle	Landrieu	Wyden
Dayton	Lautenberg	
Dodd	Leahy	

NAYS—55

Alexander	Dole	McConnell
Allard	Domenici	Miller
Allen	Ensign	Murkowski
Baucus	Enzi	Nickles
Bennett	Fitzgerald	Roberts
Bond	Frist	Santorum
Breaux	Graham (SC)	Sessions
Brownback	Grassley	Shelby
Bunning	Gregg	Smith
Burns	Hagel	Snowe
Campbell	Hatch	Specter
Chafee	Hutchison	Stevens
Chambliss	Inhofe	Sununu
Cochran	Jeffords	Talent
Coleman	Kyl	Thomas
Cornyn	Lincoln	Voinovich
Craig	Lott	Warner
Crapo	Lugar	
DeWine	McCain	

NOT VOTING—2

Kerry	Lieberman

The amendment (No. 1066) was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, very briefly, it is almost 6:25, and we have just completed our 12th rollcall vote. We still have a fair amount of work to do. But in discussion with the managers of the bill and the Democratic leader, it is our intent to finish this bill tonight. I optimistically think we can finish in 2 or 3 hours, or this bill can go until midnight, or 1, or 2, or 3 in the morning.

Part of the problem we are having now is that people are still coming up and submitting amendments, and because we have been working in good faith over the last 2 weeks in the amendment process, we have not set strict filing deadlines.

Now that we are in the last several hours of consideration, I want to make the case and, in fact, plead with my colleagues that any amendments that need to be considered—let us hear about them. Let the managers hear about them in the next 15 minutes. That is the only way we can get a list to deal with them, and we will have rollcall votes on those that are necessary.

There will be a certain number of those amendments looked at by the managers. The ones I encourage you to bring to them for consideration to be accepted need to be budget neutral and have bipartisan support, and they need to be scored by the CBO. People keep bringing amendments forward now. I

will ask—and then I want the Democratic leader to comment—that people, in the next 15 minutes or so, make sure the managers have the amendments. That way we can move ahead. We will finish tonight.

The PRESIDING OFFICER. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I hope we can do as the majority leader has suggested. We have had a good debate. I think this has been an excellent debate. The managers deserve credit for the way they have managed the legislation. We have had 12 rollcall votes today already. It is likely that we will have 16 or 17 by the end of the day, if not more; we had 9 yesterday. More than 50 amendments have now been considered.

I think it is time that we bring the debate to a close. There will be many more opportunities to talk about prescription drugs and health care with the array of legislative challenges that we face relating to health. I think we have been able to do a good deal, and I hope we can get cooperation now on both sides of the aisle. I hope the majority leader will hold to the commitment that we finish tonight. That would accommodate people's travel schedules tomorrow.

If we are going to do that—it is now 6:30—over the course of the next 4 or 5 hours, we have a lot of work to do even with what we know we have to vote on. I hope everybody will cooperate so we can minimize the time required to consider amendments. I hope those who may have remarks to make will perhaps hold off until after final passage and make those remarks after final passage. That would accommodate our time as well.

We will work with the majority leader to see if we can accomplish the schedule he has laid out. I hope we can do so well before the bewitching hour.

I yield the floor.

Mr. FRIST. Mr. President, when we finish this bill tonight, my expectation would be that we would not have votes tomorrow. That is assuming we are going to finish. I encourage anyone who has an amendment that needs to be considered to get it to the managers within the next 15 minutes. If we can do that, we can finish tonight and we will be able to consider each of those amendments, as the Democratic leader said.

I know some people want to talk for an hour but I ask Senators to keep their comments to a few minutes and we can vote throughout the night. We will have the opportunity after final passage tonight, or through tomorrow, to make statements—for those who wish to continue the debate.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, I rise to address this bill. I had hoped to do it earlier in the day but, unfortunately, the managers of the bill were unable to work the time in. I certainly regret taking time out of the schedule, which is obviously crowded. I do think it is important to speak up on the issue of this piece of legislation.

This is the most significant piece of spending legislation, and maybe even public policy legislation, outside of an international issue, that I expect I will vote on in my tenure in the Senate. Ironically, when I ran for this job, after serving as Governor of New Hampshire, one of the reasons I sought the job and one of the reasons I wanted to pursue a term in the Senate was that I was concerned about entitlement spending. In fact, during my first few years, I aggressively pursued setting up an entitlement commission to address entitlement spending, which I sponsored with Senator Kempthorne, who came in with me that year, and Senator Coverdell and Senator BENNETT, all of whom came in the year I was elected, in a bill to end unfunded mandates, many of which were entitlement oriented.

I tried to lead an effort in passing legislation to address reform of the Social Security system. I consider that to be a huge entitlement that we confront. My basic reason for seeking entitlement reform and responsibility was that I was concerned that it not only is what is driving the deficits of our country—which they continue to do—but, more importantly, as the demographics shifted in the Nation and we saw the baby boom generation, which represents a huge population, moving toward retirement, we, as a nation, were going to be placing on our children and our children's children an inordinate burden in the area of taxes in order to support the older generation—my generation—which would be retiring. It is because all the major programs, whether they are Social Security or Medicare, are built on the theory that there is a pyramid out there, that there will always be more people working and a lot more people working than those people who are taking their retirement benefits out of the system. That, of course, is the way it began.

Back in 1950, there were 12.5 people working for every person who retired under Social Security. Today, we are down to 3.5 people working for every 1 person retired on Social Security and under Medicare, and that is stressing the system.

Unfortunately, when we hit the retirement situation for the baby boom generation, the largest generation in the history of our Nation, the generation born between 1946 and 1955, we go down to two people working for every one person retired. We go from a pyramid to basically a rectangle, and the result is that we will end up putting an inordinate amount of stress on those people who are working to support those folks who are retired. So we need to address thoughtfully any entitlement expansion, to say nothing of the entitlements that are already on the books.

That is what brings me to the Chamber today to address this legislation because I believe very strongly that needy senior citizens should have a drug benefit. Clearly, prescription drugs have become the new way to treat disease and maintain public health in our Nation. We have been able to move from a system where you had to have invasive activity in the health care system, where you had to go through surgery, to a system where people can, as result of the keen use of our scientific community, take a pharmaceutical and actually have a better life than if they were to go under the knife, have surgery.

This is a revolution, and it is a revolution that is exploding and growing. Biotech activity, the nanotech activity, is only going to lead to more and more and better and better pharmaceuticals coming on the market to help people with their health.

It is absolutely unfair, in my opinion, that people who are in a low-income situation, especially retired people who are on a fixed low income, have to choose between their food and their housing and maybe their pharmaceuticals. That is not right in our society, and we can certainly afford to have that addressed.

It was my hope as we brought forward a pharmaceutical drug benefit for senior citizens that we would do it in a way that would address low-income seniors. Equally important, it is important that a middle-income senior should not have to spend all their assets for health care as a result of pharmaceutical costs. After a certain amount of spending, there should be catastrophic coverage that kicks in, relieving that person of the full responsibility or a large portion of their responsibility for the pharmaceutical cost. That is the type of structure at which we should be looking.

Putting in place this brand new drug benefit, we also have to look at the underlying Medicare system which we all know is fundamentally broken as we look out into the future. When the baby boom generation hits, it simply is not going to work. It is not going to support that generation. That is because it is a 1959 design, an automobile built in the fifties driving on the highways of the year 2000 which, when it gets to 2015, is going to be too old to function effectively. It needs to have put in place forces which are going to cause it to be more efficient, to be more effective in addressing a person's approach to their health care. Those forces have to be basically marketplace oriented. They cannot be price-control oriented.

My hope, my goal, my belief was that we would create a drug benefit that would help low-income seniors and, at the same time, give catastrophic coverage, and that would, fundamentally, reform the Medicare system so that we would end up with a more market-oriented system, something that was going to contain costs as we moved into the outyears.

What did we get? What is before us today? Essentially, what we have before us today is a drug benefit that will plant a fiscal disease that will afflict our children and our children's children. It is a drug benefit that is going to put in place a fiscal disease that will afflict our children for the next 75 years. By afflict them, I mean that our children and our children's children, under the benefit in this bill, are going to have to pay $6 trillion. That is the estimate. That may be the high end. It is somewhere between $4.6 trillion and $6 trillion. When you get into those numbers, it is pretty hard to get very definitive.

That is the burden this drug benefit in this bill puts on our children and our children's children to support my generation which is going to retire and take advantage of it.

That is a huge problem because what we are essentially saying to the person who is working in a restaurant or working in a garage or working on a computer line or working as a sales person, who is young and trying to raise a family, is that they are going to have to pay an inordinate amount of tax burden to support people who are retired with this drug benefit.

That would not be so bad if the drug benefit was not an income transfer from that person working in that garage, working in that restaurant, or working on that computer line to somebody who is a great deal wealthier than they are potentially. That would not be so bad if it was a transfer from that person to people who are low income or whose assets are about to be wiped out because of a drug expenditure.

That is not the way this bill works. The way this bill works is essentially to nationalize the entire drug delivery service for senior citizens to take all the present programs which presently benefit senior citizens for drug benefits—and there are a lot of them; there are a lot of seniors in this country today who already have a drug benefit; something like 76 percent is the estimate—to take a large percentage of those people and move them from their private programs to the public programs.

If you retired from a major corporation or even a smaller corporation in this country, it is very likely that in your retirement package, depending on how aggressive your union was or how successful your company was, you received a drug benefit during your retirement. But when this bill passes, the incentive is going to be to take that drug benefit which presently exists in the private sector under some sort of contractual agreement which you had when you retired and move it out of the private sector and throw it on the taxpayers of America.

Who are those taxpayers going to be? They are going to be our children and our children's children, people who are working for a living, trying to buy their kids a better education, a better home, better food, or even just a nice car or a night out at the movies. Their ability to do that is going to be undermined if this bill goes forward in its present form because so much will have to flow back to benefit people who already have the benefit in the private sector and are now going to be migrated over to the public sector.

Mr. President, $4.5 trillion to $6 trillion is a huge amount of money, a huge burden to put on our children. It is hard to put it in terms that are realistic and are visible when we are talking those type of dollars, but every American child born tonight—and there are a lot of kids being born tonight in America—starts out with a $44,000 debt they have to pay for Medicare for my retirement, for the retirement of everybody in this room, for the retirement of most of the people who are watching who are over the age of 45. They start out with a $44,000 debt.

When this bill passes, they will have another $12,000 to $15,000 added to that debt. So before they get through the first night of their life, as a result of this legislation they are going to owe $60,000. It is not fair. It is not right. We are not doing it the correct way.

There are ways to do this where the system is not nationalized, where all the people who already have a drug benefit are told there is no incentive for them to keep it.

We do not say in the private sector to the people who bought Medigap, to the people who have reached contractual agreements in retirement, to the people who have retained retirement coverage through the private sector, that there is no advantage to them keeping their program or, alternatively, the people who are giving them that program saying they are not going to give it to them anymore, and move those folks onto the public dole, onto the public system. It makes no sense.

Then there is the issue of the underlying question of Medicare. Not only is the drug benefit in this bill fundamentally flawed because it migrates huge numbers of people off the private sector and into the public sector, but the underlying purpose of the Medicare effort in this bill is flawed. If we are going to put in place this huge new benefit for seniors, and especially if it is going to be as grand and as pervasive, where we are basically saying to all seniors that they get a benefit here, no matter what their income is—if that is going to be put in place, that ought to at least be coupled with some sort of reform of the underlying Medicare system to try to bring under control those costs which are driving the outyear liability, which will be the tax burden for our children and their children.

The estimated outyear cost of Medicare that is unfunded is $13.3 trillion. When the baby-boom generation starts to hit the system in 2008, that is when it really starts to crank up, by the year 2020, 2025, when there will be large retirement populations as a result of this demographic shift, $13.3 trillion of unfunded liability.

Unfunded means it is just there. We have to pay it, but nobody has an idea of how they are going to do it. There is no trust fund for it. There is no money out there to do it. So the only way it is going to be done is to raise taxes or to cut the benefit, which is politically probably impossible, so to raise taxes on the young people who are working.

There is a third way, however, to do it, and that is to make Medicare a more cost-sensitive, more thoughtful, more efficient system for delivery of health care. Regrettably, under this bill that does not happen. There is a representation that that might happen, something called a PPO, which is supposedly going to create an opportunity for the private sector to come in and compete with the traditional Medicare system. The price control system will have a chance to compete with a marketplace system. That is the thematic statement of the bill. Unfortunately, it is illusory. It will not happen under the bill. CBO says maybe 2 percent of the people will migrate, will move over, to a PPO system. The administration says it is 48 percent. Logic tells us it is not going to fly, because the bill has been structured to defeat the probability a PPO, a marketplace system, will be allowed to work. All the little gimmicks in this bill are aimed at essentially undermining that.

Classic was the amendment that we passed earlier, which had been so gerrymandered, which was an effort by Senator KYL. So what are we told? Well, even though the bill has these fundamental flaws of having a drug benefit that migrates a large number of people out of the private sector into the public sector and essentially causes low-income working Americans who are young to have to support middle-income Americans who are retired and who had a private sector benefit, and even though the bill has this illusory marketplace representation, basically no real reform of Medicare, we are told we should vote for it because it is going to be improved in conference. At least that is what we are being told on our side of the aisle. I do not know what is being said on the other side of the aisle. Maybe they are not getting that same message. We are being told that by the administration.

The problem is, we are betting on the come. I mean, this is $6 trillion of unfunded liability we are talking about passing on to our kids. It is massive. If this bill were to pass in its present form, or anything near to its present form, it would fundamentally extinguish the torch which the Republican Party has allegedly—and I thought pretty effectively—carried for years which was the torch of spending responsibility.

That is why I came here, as I said when I began my statement. I came to try to do something about controlling the rate of growth of spending in the Federal Government, especially in the area of entitlements. I was told by one of the finest legislators I have ever met

in my experience in 20 years in Government—a man named Barber Conable—one time on the floor of the House when I was mumbling about the fact that some bill was coming through that was a little expensive, you have to understand, JUDD, all Government moves to the left, and it is just a question of how many engines are on that train—think of it as a train—as it moves to the left, and our job as fiscal conservatives is to limit the number of engines that go on that train.

This bill, if it passes in its present form, is going to be all engine, and it is going to undermine our capacity to assure our children they have the opportunity to have the type of lifestyle which we have, because it is going to put a huge and unfair tax burden on them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. Mr. President, this morning one of the very able legislative assistants who has worked on this legislation for almost 7 years, going back to the time on the Medicare Commission when we first started doing Medicare reform, was on the floor working with me on amendments in this legislation. She had to temporarily leave because at 5:47 this afternoon she had a little baby girl. That is a very good excuse to not be on the Senate floor. But my legislative director, Sarah Walter, is doing fine. It is a baby girl. The name is yet to be determined, but I wanted to bring that to the attention of my colleagues and all of her colleagues on the professional staff.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho.

AMENDMENT NO. 1087 WITHDRAWN

Mr. CRAIG. Mr. President, this afternoon I will speak to amendment 1087. That amendment was pulled up last night by the manager of the bill, Senator GRASSLEY. I believe that amendment is at the desk.

The PRESIDING OFFICER. The Senator is correct. The amendment has been called up and is pending.

Mr. CRAIG. Mr. President, it is my intent within a few moments to withdraw this amendment, but I thought I should speak to it tonight because I am disappointed at this time that we could not get the scoring from CBO we felt would produce a revenue-neutral bill, or a cost-neutral bill, going into the final hours of this debate.

This is an amendment that produces in this legislation, and hopefully to take up in conference, a consumer-driven health care plan under the new MedicareAdvantage program all of us are talking about at this moment. The Senator from New Hampshire gave a very impassioned speech from the depths of his heart, frustrated that this bill does not balance out and provide enough of the incentives in the market that will offset and create the kind of competitive forces being designed for Medicare with the extension of prescription drugs in it offers.

For a few moments tonight, I did want to speak about that and explain it. As we get into conference with the House, the House has a consumer-driven health care concept within their legislation that is critical. It is something we ought to address.

First, the amendment before the Senate is designed to dovetail with and not disturb the overall MedicareAdvantage competitive dynamic. As a complement to MedicareAdvantage, consumer-driven health care plans would be subject to the same competitive rules as preferred provider organizations.

Second, I emphasize this amendment is carefully crafted. We thought it would ensure budget neutrality. But CBO says tonight, no, and I am not going to be too critical of them; we pushed them very hard in the last good number of days to quickly analyze and bring forth estimates. I think they are simply swamped. We will continue to work with them. We believe what we are offering is budget neutral.

Additionally, the Finance Committee chairman, the majority leader, and the White House have expressed the kind of support for these concepts in amendments. I appreciate it. As everyone begins to examine this structure, they become increasingly enthusiastic that this could become a component of the MedicareAdvantage Program.

For the benefit of my colleagues, let me describe for a moment the key features of this amendment. The amendment establishes a new category of competition within Medicare Advantage designed to encourage participation by consumer-driven health plans. These plans would be subject to the same requirements of PPOs in MedicareAdvantage, including prescription drug benefits and risk adjustment parameters.

Consumer-driven health care is one of the fastest growing innovations emerging in the employer health insurance market. Already 1.5 million Americans are estimated to be in consumer-driven health care in the summer of 2002, and that number is now growing very rapidly.

What is the consumer-driven health care? It harnesses market forces in ways similar to medical savings accounts. However, there are some differences between medical savings accounts and consumer-driven health care plans. For example, enrollees in consumer-driven health care do not have to make contributions to the account. In the private sector, the employer or in my amendment if it were to pass, Medicare makes the contribution to the personal care account. There would be no tax consequence for the senior under this amendment. In other words, it would not be viewed as income. Some in Congress might be familiar with the account because the American Postal Workers Union of the AFL–CIO consumer-driven health care plan is now available. It is in that bundle of choices that Federal employees have today to choose from. More and more employees are signing up for this concept.

This is what the union Web site states: We believe that people who have more control over how their health care dollars are spent are more satisfied consumers and the APWU health plan consumer-driven option is designed to give that kind of control.

It is the very thing the Senator from New Hampshire was talking about. It is what we ought to be striving for to balance off the differences and to create the competitive forces within the MedicareAdvantage program.

Benefits make sense in consumer-driven health care plans. I draw your attention to my chart. My amendment is designed to encourage market flexibility. The information on this chart is one example of what consumer-driven health care plans can provide. Web site education and decision support is one example. In other words, you can go to the Web site, look at it, make choices and decisions based on the best available information. 100-percent preventive care coverage—the very kind of thing we want in modern medicine today. Preventive benefits keep healthy people healthy instead of making the repairs after the human body breaks down.

There are no more barriers to necessary care, including annual physicals, mammograms, and preventive services. All are within this kind of health care plan. All are available today offered by the postal workers.

Patient control of personal care accounts for routine health care services are also included. Unused funds in these accounts then roll over into the next year.

High deductibles, that is true insurance, to protect against financial ruin in an acute health care crisis, in other words, catastrophic coverage.

A limit on annual out-of-pocket spending is an especially important feature. Traditional Medicare does not have an out-of-pocket limit and drives many seniors into bankruptcy. In other words, it limits financial risk when it kicks in at a certain point.

It includes care coordination, disease management, and provider network discounts. Consumer-driven health care gives control of health care back to patients. That is why more and more are enrolling in it. We know today, many who work in the health care area with our seniors know they look at the details of their spending; they look at the billing; they know more about their health care and what is being charged than most people realize. Patients and their physicians, ultimately, with this kind of insurance, join in partnerships to seek the finest care at the most reasonable costs.

Consumer-driven care is especially suited for patients who like to be personally involved in their health care decisions. More and more Americans who can use the necessary information

want that kind of personal involvement.

Consumer-driven care eliminates wasteful Medicare spending, it increases patient awareness of health care costs, and encourages prudent purchasing of health care services. Any unspent funds in the personal care account would be returned to the Medicare trust fund upon the death or the disenrollment. That is a key factor. Federal dollars go into the trust fund and, if there are dollars remaining, they flow back into the trust fund of Medicare upon disenrollment or the death of the individual.

This amendment would be an important addition to the bill. I wish we could get it into the bill tonight. But it would be unfair to the manager of the bill at this time because it cannot get scored. I would not want to drive the cost up of the already-fixed segment of the MedicareAdvantage side. Already, it is less competitive than we would like it to be. I don't want to add to that disadvantage.

We believe ultimately that this will be a budget-neutral program. At that time, it will be the right thing to offer as part of the dynamics that we want to see in a modern health care delivery system and in an improved Medicare with a prescription drug program.

I thank my colleagues for listening. We will return with this when it is a final product. It may well make it into the conference between the House and the Senate. We will be working with our colleagues in the House because they have already provided that kind of a provision within the legislation which they are currently debating and voting upon.

With that, I ask unanimous consent to withdraw amendment No. 1086.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 1086) was withdrawn.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Since Medicare was established in 1965, people are living longer and living better. Today Medicare covers more than 40 million Americans, including 35 million over the age of 65 and nearly 6 million younger adults with permanent disabilities.

Congress now has the opportunity to modernize this important Federal entity to create a 21st century Medicare Program that offers comprehensive coverage for pharmaceutical drugs and improves the Medicare delivery system.

The proposal before the Senate would make available a voluntary Medicare prescription drug plan for all seniors. If enacted, Medicare beneficiaries have access to a discount card for prescription drug purchases starting in 2004. Projected savings from cards for consumers would range between 10 to 25 percent. A $600 subsidy would be applied to the card, offering additional assistance for low-income beneficiaries defined as 160 percent or below the Federal poverty level. Effective January 1, 2006, a new optional Medicare prescription drug benefit would be established under Medicare Part D.

This bill has the potential to make a dramatic difference for millions of Americans living with lower incomes and chronic health care needs. Low-income Medicare beneficiaries, who make up 44 percent of all Medicare beneficiaries, would be provided with prescription drug coverage with minimal out-of-pocket costs. For these seniors, copayments would not exceed 20 percent of the cost of the drugs.

For medical services, Medicare beneficiaries will have the freedom to remain in traditional fee-for-service Medicare for drug coverage, or to enroll in Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), also called MedicareAdvantage, which offers beneficiaries a wide choice of health care providers, while also coordinating health care effectively, especially for those with multiple chronic conditions. MedicareAdvantage health plans would be required to offer at least the standard drug benefit, available through traditional fee-for-service Medicare.

The legislation which is pending has been worked on, now, for many years. I congratulate the chairman of the committee, Senator GRASSLEY, and the ranking member, Senator BAUCUS, for the outstanding work which they have done. This is an extraordinarily complex subject, and it is a very complex bill.

We already know that there are many criticisms directed to this bill at various levels. Many would like to see the prescription drug program cover all of the costs without deductibles and without copays. There has been allocated in our budget plan $400 billion for prescription drug coverage. That is, obviously, a very substantial sum of money. There are a variety of formulas which could be worked out to utilize this funding. The current plan, depending upon levels of income, provides a deductible, then a copay, then what is called a donut hole where the recipient pays the entire costs of their drug coverage, and when it gets to a certain high level, it is catastrophic and there is coverage that pays almost all of it.

As I have reviewed these projections and these analyses, it is hard to say where the line ought to be drawn. It is a value judgment as to what deductibles ought to be, and for whom, and what the copays ought to be and for whom. I am seriously troubled by the so-called donut hole. But it is calculated to encourage people to take the medical care they really need, and at lower levels of income to have certain copays, which it is projected will be affordable. Then, when the costs move into the so-called catastrophic range, to have the plan pay for nearly all of the medical costs.

I think passage by the Senate would be a significant step forward. The House of Representatives, as usual, has a different plan—as is customary, with our bicameral legislative approach. Then the bill can be improved in conference.

The legislative process has the committee turning out a bill, and then many amendments, which generally are not known to Members in advance of brief debate and then votes. It is in the conference, after the bill is analyzed, that another fresh look is taken at the bill to produce the best legislative product in the public interest.

AMENDMENT NO. 983

I have already offered an amendment relating to end of life directives, number 983, which was adopted by unanimous consent.

Commenting on it very briefly, we find statistically that nearly 30 percent of Medicare expenditures occur during a person's last year of life. We find, beyond the last year of life, a tremendous percentage of medical costs occur in the last month, in the last few weeks, in the last week, or in the last few days.

Nobody should decide for anybody else what that person should have by way of end-of-life medical care. What care ought to be available is a very personal decision.

The living wills would give an individual an opportunity to make that judgment, to make a decision as to how much care he or she wanted near the end of his or her life and that is, to repeat, a matter highly personalized for the individual.

But if that decision was made to eliminate some of the very high costs at the very end of life, there would obviously be substantial savings to our medical system. As long as that comports with the will of the individual, that is something which ought to be considered.

The amendment directs the Secretary of Health and Human Services to include in its annual ''Medicare And You'' handbook, to be provided to each beneficiary, a section that specifies information on advanced directives and details on living wills, durable powers of attorney for health care, and directs the Secretary of HHS, in the introductory letter to the ''Medicare And You'' handbook, to reference the inclusion of advanced directives.

AMENDMENT NO. 1085

I have also submitted an amendment which is pending at the desk, amendment No. 1085, which has not yet been acted upon but which I will call up at an appropriate time.

This is an amendment which would update the Medicare physician fee formula. It is a sense-of-the-Senate resolution. The projections from the Medicare payment formula called for a 4.4-percent reduction on March 1, which would have been very problematic. The fact is, the Center for Medicare and Medicaid Services, CMS, now projects a Medicare conversion factor figure of 4.2 percent will be projected for the year 2004. This reduction threatens to destabilize an important element of the

Medicare Program; namely, physician participation and willingness to accept Medicare payments. This instability is a result of the sustainable growth rate, a system of annual spending which targets physicians' services under Medicare.

This sense-of-the-Senate amendment would provide that the conferees on Medicare reform and prescription drug legislation should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years, and should consider adding provisions which would mitigate the swings in payment, such as establishing multiyear adjustments to recoup the variance and creating tolerance corridors for variations around the updated target trend.

AMENDMENT NO. 1118

I have also submitted an amendment designated as amendment No. 1118, which provides for a lifestyle modification program demonstration. This is projected on the factor that heart disease kills some 500,000 Americans each year. The costs of coronary disease currently relate to an expenditure of some $58 billion annually. There has been a test program of the Medicare lifestyle modification program operating in some 12 States which has been demonstrated to reduce the need for coronary procedures by 88 percent. This program could reduce cardiovascular expenditures by as much as $36 billion annually.

Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater. This program has also been applied to men with prostate cancer, who have shown significant improvements in prostate cancer markers using a similar approach in lifestyle modifications. My amendment expresses the sense of the Senate that the Secretary of Health and Human Services should carry out the lifestyle modification program demonstration at the national level and then provide it on a permanent basis, and include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis.

I have submitted one additional amendment, which is No. 1128 and which relates to State pharmaceutical assistance programs for the elderly and disabled. Currently, 18 States have comprehensive pharmacy assistance programs which provide prescription drug coverage for more than 1.1 million older and disabled Americans.

In my own State, Pennsylvania's Pharmaceutical Assistance Contract for the Elderly, known as PACE, established in 1984 provides prescription drug coverage to 230,000 Medicare beneficiaries, the vast majority of whom have incomes below 160 percent of the Federal poverty level. This enrollment is comprised largely of 70- and 80-year-old widows who have multiple diseases and limited educational background who have been enrolled in the PACE program for more than a decade.

There is a serious concern that if there is not a coordinated program, people will not be informed as to how to move from PACE to another program. This affects not only Pennsylvania but, as I stated, 17 other States.

The pending bill does not provide for coordination of benefits between State pharmaceutical programs and private insurers. Without a coordination of benefits for State plans to facilitate enrollment in private plans, many of these State program beneficiaries will be unable to assess the new Medicare drug benefit.

This amendment provides for coordination of benefits between States and private insurance companies and facilitates the enrollment of State pharmacy assistance beneficiaries in the private plans. Without this amendment, the majority of seniors enrolled in their State pharmacy programs will not be able to effectively access private plans.

I note the presence of other Senators who are seeking recognition. I attempted to be brief in my general statement about the bill and also in my descriptions of these four amendments, one of which has already been adopted.

I ask unanimous consent that at the conclusion of my remarks, there be printed in the RECORD a summary of the end-of-life directive amendment, a summary of the updating of the Medicare physician fee formula, a summary of the lifestyle modification program, and a summary of the State pharmaceutical assistance programs for the elderly and disabled, and also printed in the RECORD at this point the amendments themselves.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SUMMARY ON THE END OF LIFE DIRECTIVE AMENDMENT

The purpose of this amendment is to make it easier for individuals to make their own choices regarding their treatment when nearing the end of their life.

A health care advance directive is a document where a beneficiary gives instructions about their health care if, in the future, that beneficiary cannot speak for him or herself. The beneficiary can give someone they name (''agent'' or ''proxy'') the power to make health care decisions on their behalf. They may also give instructions about the kind of health care they do or do not want.

In a traditional Living Will, a beneficiary would state their wishes about life-sustaining medical treatments if he or she is terminally ill. In a Health Care Power of Attorney, one appoints someone else to make medical treatment decisions for the beneficiary if they cannot make them on their own.

Unlike most Living Wills, a Health Care Advance Directive is not limited to cases of terminal illness. If the beneficiary cannot make or communicate decisions because of a temporary or permanent illness or injury, a Health Care Advance Directive helps them keep control over important health care decisions.

Observers have long noted that individuals incur the majority of health care costs in the last few months of life. Nearly 30 percent of Medicare expenditures occur during a person's last year of life.

Your amendment directs the Secretary of HHS to include in its annual ''Medicare and You'' handbook, which is provided to each beneficiary, a section that provides information on advanced directives and details on living wills and durable power of attorney for health care; and directs the Secretary of HHS, in the introductory letter to the ''Medicare and You'' handbook, to reference the inclusion of advanced directives information.

SUMMARY ON THE AMENDMENT TO UPDATE THE MEDICARE PHYSICIAN FEE FORMULA

Earlier this year, Congress passed legislation as part of the Fiscal Year 2003 Omnibus Appropriations bill (H.J. Res. 2) that avoided an impending 4.4 percent cut in the Medicare conversion factor. Although this change resulted in a welcomed 1.6 percent increase in the Medicare conversion factor for 2003, the Centers for Medicare and Medicaid Services' (CMS) preliminary Medicare conversion factor figure predicts a 4.2 percent reduction for 2004.

It is clear that this scheduled 4.2 percent reduction in the physician reimbursement formula threatens to destabilize an important element of the Medicare program, namely physician participation and willingness to accept Medicare patients.

The primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare.

The sustainable growh rate (SGR) system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for the immediate recoupment of the difference.

Both administrative and legislative action are needed to return stability to the Medicare physician payment system.

In its March 2003 report, the Medicare Payment Advisory Commission (MedPAC) stated that if ''Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary in 2004.''

With 17 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania's physicians have already suffered a $128.6 million loss, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $553 million or $17,396 per physician for the period 2003–2005.

Your amendment expresses the sense of the Senate that the conferees on Medicare reform and prescription drug legislation should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating ''tolerance'' corridors for variations around the update target trend.

SUMMARY OF THE AMENDMENT ON THE LIFESTYLE MODIFICATION PROGRAM

Heart disease kills more than 500,000 Americans per year. The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58 billion annually.

The Medicare Lifestyle Modification Program (also known as the Dean Ornish Program for Reversing Heart Disease) has been operating throughout 12 states and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36 billion annually.

Lifestyle choices such as diet and exercise effect heart disease and heart disease outcomes by 50 percent or greater.

Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dieticians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

The National Institutes of Health estimates that 17 million Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

Lifestyle modification programs are superior to medication therapy for treating diabetes. Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification. These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

Your amendment expresses the sense of the Senate that the Secretary of Health and Human Services should carry out the Lifestyle Modification Program Demonstration at the national level on a permanent basis and include as many medicare beneficiaries as would like to participate in the project on a voluntary basis.

SUMMARY OF THE AMENDMENT ON STATE PHARMACEUTICAL ASSISTANCE PROGRAMS FOR THE ELDERLY AND DISABLED

Currently, 18 states have comprehensive pharmacy assistance programs that provide prescription drug coverage to more than 1.1 million older and disabled residents.

The majority of these beneficiaries receive life saving medications to treat high blood pressure, heart disease, arthritis, diabetes, and eye disease.

Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE), established in 1984, provides prescription drug coverage to 230,000 Medicare beneficiaries, the vast majority of whom have incomes below 160% of the federal poverty level. This enrollment is comprised largely of 70 and 80–year-old widows who have multiple disease states, and less than a tenth grade education, and have been enrolled in PACE for more than a decade.

Currently, the pending bill the Senate does not provide for 'coordination of benefits', between state pharmaceutical programs and private insurers. Without a coordination of benefit mandate and a role for the state plans to facilitate enrollment in private plans, many of these state program beneficiaries will not be able to access the new Medicare drug benefit.

This amendment provides for the coordination of benefits between states and private insurance companies, and facilitates the enrollment of state pharmacy assistance beneficiaries into private plans, without this amendment the majority of the seniors enrolled in their state pharmacy programs will not be able to effectively access private plans.

AMENDMENT NO. 983

(Purpose: To provide medicare beneficiaries with information on advance directives)

On page 676, after line 22, insert the following:

SEC. ___. PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b-2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking ''The notice'' and inserting ''(1) The notice''; and

(3) by adding at the end the following:

''(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

''(B) In this section:

''(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

''(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.''.

AMENDMENT NO.

(Purpose: To permit existing State pharmaceutical assistance programs to wrap around the coverage provided by Medicare Prescription Drug plans and to facilitate the enrollment of eligible beneficiaries for prescription drug coverage)

On page 133, after line 25, insert the following:

''(3) COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

''(B) ELECTION.—Under the process established under section 1860D–3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or MedicareAdvantage plan through the existing State pharmaceutical assistance program.

''(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—In this paragraph, the term 'existing State pharmaceutical assistance program' means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004.''

AMENDMENT NO. 1085

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating ''tolerance'' corridors for variations around the update target trend.

AMENDMENT NO.

(Purpose: To express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

Mr. SPECTER. I thank the Chair. I yield the floor.

Mr. REID. Mr. President, I ask unanimous consent that the distinguished Senator from West Virginia be recognized to speak on the bill for up to 20 minutes and that following his statement, the Senator from Florida, Mr. GRAHAM, be recognized for 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from West Virginia.

Mr. BYRD. Mr. President, I thank the distinguished Democratic whip for his thoughtfulness and courtesies.

Mr. President, just last month we celebrated Older Americans Month, a time of reflect on the contribution of older Americans to our society—to their families, their communities, and their Nation. For many seniors, these ''golden years'' are the most valuable time in their lives, a time when they may no longer have the day-to-day aggravations of work, and can concentrate their time and efforts on something else—grandchildren, lifelong passions, learning new skills, acquiring knowledge, or participating in creative endeavors.

But that is not the case for many seniors. In too many instances, seniors who have worked and saved a lifetime find that today's cost of living far exceeds the level they can afford. Despite planning and frugality, today's costs simply have exceeded the means of many older Americans, and they find that the visions of the secure life they had expected post-retirement are now more a nightmare than a dream.

A big part of the problem is the value that our society places on the elderly—it is much too low!

Age discrimination is all too prevalent in the workplace. Long-held stereotypes—that seniors are slow, forgetful, less competent than their younger counterparts—limit opportunities for older workers and prevent businesses from benefiting from well-honed talents. Those stereotypical images are just plain wrong.

To be 65 today is not like it was to be 65 when I was a young man. The idea of pushing senior citizens out of the door to make room for younger workers is, itself, antiquated.

I grew up during the Great Depression when one had to work hard just to get a job and then work even harder to keep it. People of my generation, the generation Tom Brokaw has referred to as ''The Greatest Generation''—I kind of like that term, ''The Greatest Generation,'' although I don't quite agree with it.

Seniors in the workforce can be a positive and inspiring force.

The reason I don't agree with it is that I think the greatest generation was that generation that produced the Constitution of the United States and produced this constitutional system of government that we have today. We will talk more about that on a later day.

I grew up during the Great Depression when one had to work hard, as I say, just to get a job and then work harder to keep it. People of my generation, coming from that experience, developed a work ethic which can inspire young people today. Seniors in the workforce can be a positive, inspiring force. Moreover, better health care and healthier lifestyles have extended lifespans and led to a senior population with vigor and vitality.

But when the health of seniors does decline, this Nation does an embarrassingly poor job of dealing with their needs. Child care has become a booming business in this Nation. Millions are spent on bigger, brighter, better child care centers—lively places, filled with happy activities and stimulation. That is as it should be. But when the elderly need daily care, too often they are relegated to dim, overcrowded centers, places that serve as little more than warehouses that provide busy work for the hands, and little to fill the heart and soul.

Inestimable numbers of scam artists focus on the elderly. The offices of Attorney Generals across the nation are besieged with complaints from seniors who were prey for some con artists and ended up losing their life savings. Newspapers carry stories about CEOs of big, once-profitable companies who are awarded big bonuses, while the pensions of loyal retirees are squeezed. When this is how we treat our seniors, something is wrong with America.

Older citizens should rejoice in their long lives, in their collected experiences, and in their accomplishments. But in America today, magazines showcase images of young, vibrant models. Movies and television shows feature youthful actors and actresses. No one wants to be ''old'' anymore. It has become a tarnished word.

Older citizens today are generally not appreciated as either experienced ''elders'' or possessors of special wisdom. Older people are respected only to the extent that they remain capable of working, exercising, and taking care of themselves. In American culture, increasing age seems to portend decreasing value as a human being. It should be just the opposite.

How did the American culture develop such blatant disregard and disrespect for the elderly? Well, however we got to such a point, we are definitely here.

Senior citizens need to rise up and make their voices heard or else they will be forgotten, especially when it comes to policy formation that directly affects them, such as Medicare legislation before us today. The Senate is in the midst of an important debate on a major restructuring of Medicare—a debate that will shape the health care choices of millions of our Nation's senior citizen for years to come.

The Medicare program is in desperate need of renovation to meet the needs of today'a older citizens living in a new era with dramatic advancements in the delivery of health care. Medicare was designed to provide health care benefits to the most vulnerable segments of the population, the elderly and the disabled.

When I voted, way back in 1965, to establish the Medicare program, pharmaceutical treatments, then more of footnote in health care, were not nearly as commonly available as they are now.

Today, they are a primary form of medical care and often substitute for more costly treatments like hospitalization and surgery.

Today, 40 million Americans rely on Medicare to help provide for their medical needs. With more than one-third of all Medicare beneficiaries lacking insurance coverage for the cost of needed medications, finding affordable prescription drug coverage is a critical issue for our Nation's seniors. Prescription drugs are an essential tool for treating and preventing many acute and chronic conditions, but Medicare fails to cover them on an outpatient basis. Too many seniors and disabled persons in this country, especially those living on fixed incomes, are forced to choose each month between paying for food and paying for shelter, or buying the essential medicines that their doctors have prescribed.

Our Nation's senior citizens are losing their patience. They are losing their dignity. And they are fed up with fast-rising drug costs that they cannot afford. Older citizens should not have to travel in bus loads to Canada and Mexico just to obtain the medications their doctors prescribe. What does it say about this country and its values when we fail to take care of our elderly citizens whose lifetime of work and sacrifice and dedication and industry helped to endow this country with the greatness it now enjoys?

Mr. President, I fear that the legislation before us today is a glaring example of how this Nation shortchanges our senior citizens. We are not taking care of our elderly citizens as they wrestle with the most serious issue in their lives. We are offering a partial fix to assuage senior anger. This bill fails to go far enough to meet the needs of our Nation's senior citizens. I am concerned that this measure would force Medicare beneficiaries to rely on a private, untried, untested, drug-only insurance market for their prescription drug coverage, rather than the traditional Medicare program that they know and trust. We split drug benefit off from Medicare?

I am concerned that this administration and some Members of Congress plan to phase out the traditional Medicare program as an option for new beneficiaries in the future. Some people have asserted that this legislation is merely a Trojan horse designed to get rid of Medicare. I sincerely hope that this is not the case, but there is something very suspicious about this particular horse.

I am worried that we may be endorsing the slow suicide of one of the most popular and effective Government programs in history. I have been down this tortured road before during my 50-year tenure in Congress. My constituents and others around the Nation are reeling from public programs that have been turned over to the so-called free market. Utility rates, cable rates, airline rates, you name it, the free market has ensured exorbitant prices with diminished service, especially for rural areas such as West Virginia. Pensions and retirement security have taken a similar beating.

The Medicare program, for which I voted in 1965, was originally created because the private sector did not offer affordable and reliable health insurance to the elderly and the disabled. Health care has certainly changed in the past 38 years, but what has not changed is the fact that the private market does not want to insure people who are old or disabled or likely to need care. Mr. President, what is the rationale for inventing some new hocus-pocus type of plan that exposes senior citizens to the whims of private insurance companies which may be more interested in profits than in providing comprehensive drug benefits?

Mr. President, this legislation, as currently designed, does not even provide sufficient prescription drug coverage. It would cover less than a quarter of Medicare beneficiaries' estimated drug costs over the next 10 years, and the complicated coverage formula has a large donut hole providing zero coverage just when seniors might need it most.

This legislation also includes copayments, premiums, and deductibles that may be unaffordable for man low- and middle-income seniors. The $35-per-month premium, the 50-percent copay, the $275 annual deductible, and the $5,800 stop-loss amount that we have heard so much about are only suggested amounts and certainly not a guarantee. A closer look at the fine print of this legislation reveals that private insurers could choose to charge senior citizens double or even triple these amounts.

Let's fact it, the kind of prescription drug benefit that we have repeatedly promised our Nation's elderly citizens, and that they now rightly expect, would cost at least $800 billion over the next decade. Yet the administration and congressional Republicans have only allocated $400 billion for the next 10 years for a Medicare prescription drug benefit. And during this same period, drug costs for senior citizens alone, according to the Congressional Budget Office, are expected to total almost $2 trillion.

One of the primary reasons this legislation contains such glaring deficiencies in the drug benefits being offered to seniors is not difficult to understand—this administration and Congress have chosen to make tax cuts a higher priority than prescription drugs for senior citizens. Since the Federal Treasury has already been raided, there is not enough money to adequately cover prescription drugs. Senior citizens ought to be outraged—outraged. Senior citizens ought to be outraged. I am a senior citizen, and I represent a State with a lot of senior citizens, and I am outraged! I am outraged!

What is the rationale for waiting until 2006—conveniently right after the next election cycle—to implement this legislation? Why wait? What are we so afraid of? We had Medicare up and running less than 12 months after creating it from scratch in 1965. So why can't we do it now? Mr. President, it seems that this Congress is trying to pull the wool over the eyes of our Nation's senior citizens—hoping to claim victory and keep senior citizens in the dark until they become painfully aware of the fine print—the fine print—of this legislation upon a visit to their local pharmacist in 2006.

Mr. President, this legislation, as it stands, does not provide the real, guaranteed, defined benefit that our senior citizens desperately need and does little to address the high cost of prescription drugs. I had hoped we could improve this legislation through the amendment process, but that does not appear to be the will of this Senate in the mad dash—the mad dash—to reach final passage before the recess. We should do better for our older citizens. We owe them so much.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM of Florida. Mr. President, this is a sad evening for me. I rise to oppose the prescription drug bill that we will be voting on shortly. No issue that we have debated over recent years has held so much promise, the promise that we could fundamentally reform Medicare from a program which today requires you to be sick enough to go to the doctor or the hospital in order to get services to one that would have its focus on wellness, including the opportunity to participate in a voluntary, comprehensive, universal, and affordable plan of prescription drugs.

Prescription drugs are, in today's health care system, a fundamental part of maintaining good health. I have spent the better part of the last 5 years, as have so many of my colleagues—and in the case of Senator BYRD, many more than 5 years—attempting to deliver a meaningful drug benefit for our Nation's seniors. I have learned some things during this period. Unfortunately, what I have learned convinces me that the bill before us tonight is not worthy of America's seniors. Because what we are about to deliver is a hollow promise and little else.

Why do I believe this? Why have I come to the conclusion that this proposal is not worthy of using all of the years of enthusiasm and commitment of America's seniors and many of those such as myself who represent a substantial number of those seniors? Why do we feel that this path is not acceptable?

First, there are gaps in the benefit which are too large to overcome. I could not go home to Florida or to any other place in America and tell people that this legislation is a good deal. This is especially the case for those with large out-of-pocket expenses. How do we tell a senior who halfway through the first year in which this

will be available, 2006, their drug costs will double but they will continue to pay the monthly premiums?

That would be analogous to car insurance which says: You will be covered in case you have an accident from January to August but if you have one from September to December it is out of your pocket. Who would buy that automobile coverage?

The worst thing is that millions of seniors will never realize they have bought in to such an inadequate policy until it is too late.

Second, this bill does not provide a universal drug benefit. Under this plan, for instance, if you are a Medicare beneficiary but you are also poor, you will not get the prescription drug benefits for Medicare. That is right. Seniors at 74 percent or below the poverty level would be excluded from the Medicare benefit. They would get their prescription drugs through Medicaid. This is a clear effort for the Federal Government to unload a substantial part of its prescription drug expenses on the States, States which are already struggling with serious financial problems.

It is for that reason that the National Governors Association has opposed this design saying:

It is not good health policy. It is not good precedent.

The argument is made that this is all we can do. We cannot do better because we do not have the resources to do better. This is analogous to the child who just has shot his mother and his father and now throws himself on the mercy of the court claiming to be an orphan. We have made the decision to be in the financial status that we are, and the consequence of that decision, as we debated a few weeks ago when we adopted the Senate's budget for the year, is that we are going to have to have an unnecessarily and unacceptably low level of financial support for a meaningful prescription drug benefit.

Third, this plan will cost many seniors more than they can afford. From repeated surveys, seniors have stated that they need a plan with no deductible so that coverage starts from the first prescription. And they need a premium of no more than $25 a month. Yet the sponsors of this bill suggest a $275 deductible and an average premium of $35 per month, an average premium which could actually be higher because the private insurance companies will determine the level of the premium. You can look through the over 600 pages of this bill and not find the number $35. That is a hope number but the actual number will be determined by the private insurance carriers.

Fourth, this bill would subject millions of America's seniors to a giant experiment, a giant experiment in delivering prescription drugs through an untested delivery system, a system which is unheard of in the private markets. It is stated that this system will be justified because it will be efficient and will use the power of competition to suppress cost. If this was such a good system, why don't we provide it for all Federal employees so they can get, we as Federal employees can get, the benefit of this greater efficiency and cost savings? The reason is because insuring drugs only is not an actuarially sustainable risk. It has been analogized to buying a fire insurance policy just to cover the kitchen. No insurance company is going to sell you a policy for the most vulnerable area of your house to actually experience a fire.

That is why no private insurance plan is available today which will provide you a prescription-only coverage. That is the equivalent of the kitchen in terms of its intensity and potential for explosion of cost within health care. Yet we are about to say that some 40 million of the most vulnerable and frail Americans are going to be the experiment for this ideology.

I have said it before and I will say it again: There is simply no reason to subject our Nation's seniors to this grand experiment, particularly when we already know what works. There is no reason to pump extra dollars into private insurance plans.

A few hours ago we adopted an amendment which will pump in $6 billion for additional benefits to HMOs. Those $6 billion could have been used to reduce the monthly premium, to close part of the gap of coverage. But what did we decide to do? We are going to give it to the HMOs so the Federal Government will be assuming more of the risk of coverage as opposed to these plans whose reason for being is to assume the risk and, therefore, have the incentive to provide the most efficient plans.

We are begging these HMOs to participate in the Medicare Program for the sake of a private sector veneer, for the sake of an ideology untested. We actually tried a version of this before. Guess what. It didn't work. I speak from experience. Medicare HMOs have dumped hundreds of thousands of Floridians from their rolls as they have in virtually every other State, and more are being dumped each day. But this Congress, rather than look to the reality of past experience, has determined to embark on this collision course at the expense of seniors and at the expense of common sense.

Fifth, I fear that we will have difficulty in convincing healthier seniors to sign up for this prescription drug benefit. As it is with virtually all insurance plans, it is critical that there be a mixture of those who have the greater likelihood of experiencing the risk with those who have the lesser likelihood in order to create an actuarially sound balance.

One-third of our seniors would not break even under this legislation. That is, one-third of seniors with drug spending of less than $1,135 per year would get no benefit should they voluntarily sign up for this plan. Therefore, how do we induce them to do so? One of the ways that we had induced them in the past was to have a meaningful catastrophic care provision, so that seniors who, today, are relatively healthy are insuring themselves against the risk that they might have a disease or an accident that would put them into much higher prescription drug costs.

Last year we determined that the level necessary to induce a large enough number of healthy seniors to participate was $4,000 in an annual drug expenditure, and if their previous employer made a contribution, that would be counted toward that $4,000. This bill increases the level at which a person would be eligible for catastrophic care to $5,800, and employer contributions would be excluded. This new level is significantly less of an inducement for healthy seniors to participate, and the effect is likely to be disappointing levels of participation.

Mr. President, I ask unanimous consent that a copy of today's front page article ''For Struggling Seniors, Medicare Drug Plan's Proof Is in the Purse'' from the Washington Post be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. GRAHAM of Florida. The reporter interviewed active, healthy seniors at centers in Cleveland, OH, and they were skeptical of the cost of the benefits that would be offered under this bill.

Sixth, the fact that this bill doesn't take effect until 2006 is another brutal hoax on seniors, truly an abusive, shameful, misleading ploy.

The fact is, many of those who most need prescription drug coverage today simply will not live long enough to get any benefits under this plan. As much as I have wanted to vote for a drug bill, for those reasons, I simply cannot vote for the one before us this evening.

We have lost our focus. The focus should be on the Medicare Program in reform and how to help our 40 million seniors and disabled persons. Instead, the focus is everywhere else—insurance companies, drug companies, and hiding the flaws which ought to be exposed.

This focus is often presented as the issue of choice. Choice has different meanings. For the idealog, choice means a choice among delivery systems. But for seniors, choice means doctors, hospitals, and, hopefully, prescription drugs. Yes, this gives seniors a choice among delivery systems. For instance, if you are one of the 89 percent of seniors in a fee-for-service Medicare Program, you will get a choice of between two or more prescription drug plans. If that fails, you will then drop back into traditional Medicare.

The Stabenow amendment, which was defeated earlier in the debate, would have given seniors at least real choice between a prescription drug delivery system and fee-for-service Medicare as the delivery system.

The tragedy is that we know what we ought to be doing. What we ought to be doing is building on the strengths of

our current Medicare system—one of the most popular health care programs in this Nation's history. We also ought to be seeing that we have a plan that is affordable and comprehensive.

I think the dye is cast and this bill is likely to pass the Senate. I will be hopeful that in conference it will improve but I think there is every likelihood to suspect that it will get worse. It will be my intention to introduce legislation that will correct the flaws of this legislation which, among other things, will provide for a patients' bill of rights, so that as we herd more seniors into HMOs, at least they will know the standards by which they will be asked to operate within that.

We are beginning to hear the first rumblings of dissent. Today's Miami Herald looked at the legislation before the two Houses and this is what they had to say:

House and Senate bills attempting to offer prescription drug cost relief to Medicare seniors can be summed up with the movie title, Dumb and Dumber.

Both bills promise dubious benefits without providing the security that seniors want and have, with traditional Medicare health coverage.

I ask unanimous consent that a copy of that editorial be printed in the RECORD after my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. GRAHAM of Florida. Medicare has served our seniors superbly. And where it has not, as in the area of prescription drugs, it has been because Congress has not allowed it to do so.

I hope when this bill comes back from conference, it will be better but I doubt that will be the case.

The PRESIDING OFFICER. The Senator has consumed 15 minutes.

Mr. GRAHAM of Florida. Mr. President, I will vote no today in the hopes that soon we will have an opportunity to pass a prescription drug bill that will fully meet the needs and expectations of older Americans.

EXHIBIT 1

[From The Washington Post, June 26, 2003]

FOR STRUGGLING SENIORS, MEDICARE DRUG PLAN'S PROOF IS IN THE PURSE

(By Ceci Connolly)

CLEVELAND—As the Medicare drug package moving through Congress takes on an air of inevitability, Washington politicians are already jostling for credit. But in this working-class city 370 miles from Capitol Hill, prospects for the plan's eventual success may lie deep inside the handbags of women such as Marie A. Urban.

Stashed in there are her monthly Social Security statement, a half-dozen prescription discount cards and insurance letters rejecting several recent medical claims. The scraps of paper—creased and scribbled on—document a life near the financial edge.

After working 24 years as the secretary at St. Paul's Shrine, Urban, 72 collects $843.70 a month in Social Security. After housing and Medicare payments, she has $459 for utilities, food, car insurance, taxes and medication. ''Some months I have 87 cents to live on,'' she said. With her drug bills this year already exceeding $1,500, she said she probably will try to cobble together the money to buy the prescription coverage that lawmakers plan to offer Medicare recipients.

''I don't know,'' she said. ''My finances right now are very tight. I guess I'd have to go with it.''

In interviews at two senior centers here, Urban and other retirees expressed deeply mixed feelings about the voluntary prescription drug benefit scheduled for votes in Congress as early as today. They exhibited a visceral distrust of Washington, voicing skepticism that elected officials would deliver a package that fits their health needs and budgetary constraints—in time for them to use it. They were disappointed that in most cases, benefits would not begin until a person spent nearly $1,000 a year on prescription drugs. And they were annoyed—but not totally surprised—that the program would not begin until 2006.

''They've been kicking this ball around for a while,'' said Carrie Adams, 66. ''If they wanted to solve this, they would. The people with the ball are not relating to the people out here.''

Ruby Bogus, 83, was a bit more sanguine. ''We just have to live longer, girls,'' she said.

Both the House and Senate plans would require seniors to pay about $35 in monthly premiums and an annual deductible of $250 to $275 before receiving any subsidy. The Senate plan would cover half of a person's annual drug expenditures between $276 and $4,500. The recipient would pay the next $1,300 in prescription costs. If the person's total drug costs rose above $5,800 in a year, subsidies would resume.

The House bill would offer retirees an 80 percent subsidy on drug bills between $251 and $2,000 and no coverage for the next $1,500 worth of medications. The ''catastrophic coverage'' would begin when costs reached $3,501.

Asked whether either plan was attractive, Emily Eckert pulled a tiny notebook from her purse. It listed her daily medications: two pills to control sugar, one for high blood pressure, another to regulate potassium. Using her People's Drug Mart discount card—also tucked in her pocketbook—Eckert spends about $100 a month on prescriptions, plus $22 for diabetes test strips.

At 79, she has outlived two husbands, but at a high cost. Caring for her first husband, who had cancer, and the second, who had diabetes, wiped out $7,000 in savings and two life insurance policies valued at $3,000. Eckert has been in bankruptcy and worries about helping her three children, 10 grandchildren and 10 great-grandchildren.

''If it wasn't for this center, I'd be starving,'' she said, referring to the Senior Citizens Resources facility in the Old Brooklyn neighborhood. She wants to buy the drug coverage proposed for Medicare but isn't certain she will be able to pay the premiums.

The situations of Marie Urban and Emily Eckert may sound dire, but in many respects they are typical for the millions of senior citizens and disabled people who rely on Medicare for their health care. Not poor enough to qualify for Medicaid, yet not fortunate enough to have substantial savings or a lucrative retirement package, such people have clamored for years for help with the rising cost of medication.

Assuming the House and Senate pass their spending bills and then resolve their differences, Congress hopes to answer those demands by spending nearly $400 billion on drug coverage over 10 years. The legislation would mark the largest Medicare expansion in the program's 38-year history and could provide a political boost to President Bush and fellow Republicans who campaigned on the promise of alleviating drug costs.

However, as the conversations in Cleveland illustrated, many older Americans are watching with guarded optimism and could revolt if the final package fails to meet expectations. That would dash Republicans' hopes of taking away an issue that has been mostly associated with Democrats for decades.

Their elderly residents' fundamental question is whether they would save money under the new plans. The answer isn't easy.

Urban is torn. Most years she spends about $800 on medicine, so a benefit that does not begin paying off until after $1,000 in out-of-pocket spending looks like a money loser for her. But this year, a mysterious infection and several hospitalizations pushed her drug bills to $1,500, and the federally subsidized insurance would have saved her money. Urban drives 30 minutes to several pharmacies in the Cleveland suburbs to shop for the best deals. She gets agitated thinking about the complex math of the new proposal.

Howard Bram, 77, also complained about the complexity of a program that will involve choosing a plan, tracking out-of-pocket expenses and knowing when the coverage kicks in, lapses and then resumes in severe cases, all according to a sliding scale of benefits.

''It's just gonna blow their minds,'' he said. Bram is trying to figure out whether the drug plan would put a significant dent in the cost of the eight medications he takes.

Carrie Adams and Jean Nagorski are precisely the sort of customer-patients that Medicare will need—comparatively young, healthy and with some retirement income. Yet both women doubt they would buy the Medicare drug coverage because they believe they get a better bargain with the current supplemental insurance plans. Without clients such as Adams and Nagorski, policymakers worry, the new Medicare package will draw the oldest, sickest and poorest patients, leading to skyrocketing costs.

Despite the plan's limits, Adams predicted many friends will sign up for any program that might lower their drug bills. ''They're gonna jump on this like white on rice,'' she said.

Zev Harel, 73, agreed.

''There are always those who hope for a revolution, but what has worked in the United States is evolution,'' said Harel, a professor at Cleveland State University and board member of the Western Reserve Area Agency on Aging. Many of his friends will be disappointed with the limits of the drug coverage, he said, but he considers it ''a major improvement over the current situation.''

If analyzed in the context of other types of insurance, the Medicare drug plan is a reasonable approach, Harel said. ''This follows on the principle of purchasing protection.''

But many others said the fundamental promise of Medicare—a system they supported through payroll taxes throughout their careers—has always been health care for all, and in today's world, that should include prescriptions.

''The politicians seem to say it's better than nothing, and we should be grateful,'' Urban grumbled.

To some retirees here, who chip coupons and follow the news, Washington's Medicare is just the latest example of the doings of out-of-touch elitists.

Nagorski reached into her purse and retrieved a recent newspaper clipping detailing the personal riches of the United States' elected leaders. The article identified several millionaires, including Sens. Bill Frist (R-Tenn.), Edward M. Kennedy (D-Mass.) and Ohio's senators, Mike DeWine and George V. Voinovich, both Republicans.

''Do you really think they care about the average person with what they earn?'' Nagorski asked. ''I don't think any of them are ever going to have to live on $1,100 a month.''

[From the Miami Herald, June 26, 2003]

THE WRONG PRESCRIPTION—CONGRESS CONSIDERS INADEQUATE BILLS

U.S. House and Senate bills attempting to offer prescription-drug cost relief to Medicare seniors can be summed up with a movie title: Dumb and Dumber. Both bills promise dubious benefits without providing the security that seniors want, and have, with traditional Medicare health coverage.

With election-year politicking started already, the bad news is that a bad bill may actually be enacted after years of waiting. The politicians may easily be miscalculating. Most seniors, who faithfully turn out to vote, want prescription-drug coverage through Medicare—not the private insurers that the GOP-controlled Congress and White House are pushing.

Further, an increasing number of Americans—32 percent today versus 16 percent in 1999—says that neither the Republican Party nor the Democratic Party is doing a good job on the issue of prescription-drug benefits for the elderly, according to a recent poll by the Kaiser Family Foundation and Harvard School of Public Health. The proposed congressional legislation can only deepen that sense.

Each bill would cost about $400 billion over 10 years and suffer from complexity and coverage gaps. Under the Senate bill, for instance, a senior would pay the first $275 in drug costs (the deductible), then half of the costs—up to $4,500. They would then get no benefit until the bills total $5,800 (an out-of-pocket expense of $3,700), after which 90 percent of the cost would be covered. Have you got that?

It gets worse. Beyond the deductible and co-payments, seniors would pay a monthly premium—even while getting no benefits when they are in the coverage gap. Although the premium is ''estimated'' at $35 a month, it's actually subject to a drug-cost inflator that, at the moment, is four times higher than inflation. It's also subject to interpretation by private insurers, who presumably would contract with the government to administer this plan—an uncertain assumption.

The Senate bill also provides for a ''fallback'': if a region doesn't attract two competing private insurers, the government may contract with pharmacy-benefit managers, firms that actually manage the prescription-drug programs of most large health-insurance plans. So why contract with the private insurers in the first place when these pharmacy-benefit managers have the expertise to drive down drug costs by leveraging Medicare's enormous volume-buying power?

That the pharmaceutical companies are trying to strip this fallback provision does indicate who wants the benefits here—and we're not talking about Medicare seniors.

The House GOP measure, indeed, has no fallback provision—which could leave large areas of the country without access to the Medicare drug benefit. It has the same premium problem and a bigger coverage gap. But it would provide more generous benefits: A $250 deductible and 80 percent cost coverage up to $2,000.

Neither bill offers the drug-price relief, simplicity and security that seniors need. But what do you expect from a Congress and White House that already have spent $1.7 trillion on tax cuts since 2001? Seniors, and critical Medicare and Social Security concerns, apparently only matter as talking points for an election year.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, I know the Senator from Arizona is here to speak. He will speak for 10 or 15 minutes, is my understanding.

We are at a point where we have very few amendments left. We have a couple that may take a little debate but I think most of them will be disposed of with minimal debate. I hope everyone understands we are moving this along as quickly as possible. The managers have worked for 2 weeks on this matter.

After the Senator from Arizona finishes his statement, we should be in a position to have a number of votes lined up for later this evening.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, the passage of the Medicare prescription drug benefits legislation is a difficult vote for me. It is unacceptable that in a country as wealthy as ours seniors across the country are struggling to afford the high cost of prescription drugs. I have supported adding a prescription drug benefit to Medicare because I believe no beneficiary should have to choose between life-sustaining prescription medications and other vital necessities. Far too many American seniors face those choices every day. Many ration their supplies of medication, skip dosages, or cut pills in half.

In Arizona, busloads of seniors depart from Phoenix and Tucson every week, heading south to Mexico to purchase lower cost prescription drugs. The story is similar across the northern border, where seniors make daily trips to Canadian pharmacies. Throughout the country, an increasing number of seniors are looking to online pharmacies, selling reduced-priced prescriptions imported from other countries, oftentimes with questionable safety.

That said, I also recognize, as does every other Member of Congress, that Medicare is on a fast track toward bankruptcy. The most recent Trustee's Report adjusted down the year Medicare will reach financial insolvency by 4 years, to 2026. Clearly, it is incumbent upon us to include comprehensive reform of the system in any Medicare prescription drug package in order to ensure that Medicare is financially sound for current beneficiaries as well as future generations.

Medicine has changed substantially since the creation of the Medicare system in 1965. Advances in medical technology and pharmaceuticals have led to more prescription-based treatments. The simple fact is, Americans now consume more prescriptions than ever before. In 1968, soon after the enactment of Medicare, American seniors spent about $65 a year on a handful of prescription medications. Today, seniors fill an average of 22 prescriptions a year, spending an estimated $999.

The bill before us represents one of the largest enhancements to Medicare since its creation, setting up an entirely new bureaucracy and establishing a sizable new entitlement program. I believe this bill addresses a real problem, the need to help struggling middle and low-income seniors. However, we must have no illusions. There are dangerous complexities and potential unintended consequences associated with this bill.

First, we must be realistic about the cost of this new entitlement program. For anyone who believes this bill will cost a maximum of $400 billion over the next 10 years, I have some oceanfront property in Gila Bend, AZ, to sell you.

Medicare and Social Security, together, represent an enormous unfunded liability for our Nation. In a few short years, millions of baby boomers will hit retirement age and the system will quickly become insolvent.

The numbers speak for themselves. Medicare currently has an unfunded liability of $13.3 trillion. Some have estimated the unfunded liability of the package before us in the $6 to $7 trillion range. A scholar at the American Enterprise Institute Scholar estimated that if passed, the Senate's prescription drug benefit legislation will result in a $12 trillion unfunded liability. Social Security and Medicare, with a prescription drug benefit, will together consume an estimated 21 percent of income taxes by the year 2020.

Long after the Members of this Congress and administration have left office, our children and our grandchildren, and a future Congress and administration, will be struck with the burden of cleaning up the mess we have created.

In the past 2 years, we have passed two large tax cuts. Government spending, however, has continued to increase well above the inflation use. Much of that spending is unnecessary, and represents a lack of fiscal discipline more common in times of federal budget surpluses. Yet our current budget deficit and national debt have risen dramatically. Security concerns in the post 9/11 era necessitate substantial increases in spending on defense and homeland security. We cannot sustain this level of fiscal profligacy indefinitely.

This extraordinary large new entitlement we are debating will impose an equally extraordinary burden on taxpayers. The money has to come from somewhere, and none of the ''somewheres'' are desirable. The reality is, this new benefit will be funded by raiding other entitlement trust funds, or by increasing our national debt, or by substantially increasing taxes.

Despite the enormous cost of this bill, this new entitlement will not provide the prescription drug coverage many seniors expect to receive. Nor does it enact significant reform measures needed to ensure the long-term solvency of the Medicare system.

Those seniors who think this bill will solve their financial problems will soon learn that there are substantial limitations to the benefit. When it does pass, the new prescription benefit will not be available immediately. In fact, it will take several years just to establish the new bureaucracy which will administer the prescription benefits.

Low-income seniors will benefit from this package, and I am pleased that they will. Many other seniors, however, will not receive a generous benefit, and might not even get out of the system what they will pay in deductible sand premiums. The Congressional Budget Office estimates that 37 percent of employers currently providing coverage to Medicare eligible seniors, will drop coverage if this bill passes. Last week, the Wall Street Journal quoted one analyst who called this bill the ''automaker enrichment act,'' because companies such as the automakers who currently provide their retired employees with a prescription drug benefit are unlikely to continue doing so if the Federal Government assumes part of the burden for them.

I am concerned that we are about to repeat—I emphasize repeat—an enormous mistake. I have been around here long enough to remember another large Medicare prescription drug entitlement program we enacted in 1988, Medicare Catastrophic. The image of seniors outraged by the high cost and ineffectiveness of that package should be a cautionary tale to all of us.

Moreover, I am not confident that the Medicare Advantage portion of this new scheme, which establishes regional PPO options for seniors, will succeed. Many in the insurance industry have expressed skepticism and concern that such plans will not be profitable. In the end, the Federal Government, which acts as a fallback if no private plans are available, might end up covering the majority of the country. Not exactly the reform we all had hoped for.

The American people should be aware that this new benefit has substantial cost to seniors, and to current and future generations of taxpayers, who will bear the majority of a crushing financial burden. There will be unintended consequences of our actions. We can be sure of that. Moreover, we should be honest about the cost of this measure—$400 billion is merely a down payment for what we are creating. Given the fiscal realities we face, realities that will become more dire with every passing year, Congress and the administration should have committed to addressing the acute need for a drug benefit to alleviate the impossible choices confronting lower income seniors. And, most importantly, begun to seek consensus among responsible Members of both parties for the reforms we all know are necessary to save Medicare.

I recently heard a good assessment of this package: it is ''an effort to do too much with too little, and thus doing nothing very well at all.''

There are several good amendments that have been adopted during this debate. I am encouraged that a bill Senator SCHUMER and I worked on for the last 4 years, might finally be enacted into law as part of this package. Our amendment will increase competition in the pharmaceutical industry and ensure that all Americans have access to lower cost generic drugs. That amendments, which would not have been possible without the leadership of Senator GREGG and the support of Senator KENNEDY, will reduce the cost to the government of any Medicare prescription drug benefit.

I was happy to cosponsor an important amendment with Senators FEINSTEIN, NICKLES, CHAFEE, and GRAHAM, which I believe will add some fiscal discipline to the bill and the Medicare program. The amendment will add means testing to Medicare Part B—increasing co-payments for wealthier seniors.

I am also pleased that several measures which I have supported and cosponsored as separate bills, have been adopted as part of this package, including the Immigrant Children's Health Improvement Act, the Blind Empowerment Act, and funds to reimburse hospitals for the uncompensated cost of caring for undocumented immigrants. Additionally, there have been several good amendments that I think will improve overall health care in our country. In particular, I believe Senator GRASSLEY'S amendment which requires agreements between brand and generic pharmaceutical companies to be reported to the Federal Trade Commission and the Justice Department will shine some much needed light on potential collusive agreements.

Despite these welcome improvements, and recognizing that this legislation will address the crisis faced by lower income seniors, the costs of this entitlement remain, simply put, beyond the means of this country absent real reform of Medicare. Therefore, after much thought, I regret that I cannot vote for this legislation. I have reached this conclusion, not because I believe our seniors and disabled do not need or deserve prescription drug coverage, but because I do not believe our country can sustain the cost of this benefit, which will not, despite it's staggering expense, provide the assistance many beneficiaries will expect.

As I noted, Congress and the administration should have addressed the acute need for assistance of lower income seniors. And before we consider extending that assistance to other seniors, we should save Medicare first by instituting the reforms we all know are necessary, but which we apparently prefer to defer until we have retired from public service. I know that those reforms pose a very difficult political challenge to us, and that the bipartisanship we have commended in the drafting and consideration of the legislation before us today would be put to a far more severe test should we genuinely attempt to save the Medicare system from insolvency. However, should we simply add another huge, new unfunded liability to an already fiscally unsound entitlement, imposing a breathtakingly heavy tax burden on our children and their children, with devastating consequences for their prosperity and the national economy, we will have done the one thing no public servant should want to be remembered for, we will have left the country worse off than we found it.

I yield the floor.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. ALEXANDER). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, the Senator from Michigan, Mr. LEVIN, has been extremely patient. He has been waiting for us to get a unanimous consent for his amendment. We are very shortly going to get that, but prior to that being announced, the Senator from Michigan is going to offer amendment No. 1111. He is going to speak for 10 minutes. Senator STABENOW will speak for 5 minutes, and Senator GRASSLEY and Senator BAUCUS will speak for up to 10 minutes in opposition, if they need to. The leaders will arrange a vote at some time that they have agreed upon.

I ask unanimous consent that that be the case.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Michigan.

AMENDMENT NO. 1111

Mr. LEVIN. Mr. President, the amendment which I will be offering is designed to ensure that the CBO estimate of 37 percent of current retirees who now get their prescription drug coverage from their former employer and who will lose that coverage as a result of this bill will at least have the option of a prescription drug coverage under the Medicare fallback.

There are a number of problems which have been identified with this bill. Some of them are significant problems which cause many of us, who very much favor having a prescription drug benefit available to our seniors, great pause before we support this bill. For instance, there is a so-called yo-yo effect in this legislation. Some have called it the revolving door effect. The problem there is that seniors who are offered two private plans in their service area must pick one of those private plans. They cannot use the Medicare fallback. There will not be a Medicare fallback with a guaranteed premium because if two or more private companies offer a prescription drug program, with whatever premium they decide upon, then the seniors in that service area must pick one of those two private plans.

What happens then if the senior says, okay, I am going to pick that private plan A, and then a couple of years later the private sector decides to pull out of that service area? At that point, the senior will be offered the Medicare fallback.

Then what happens if the private insurance folks decide to come back into

that service area? Could the senior keep the Medicare fallback plan? No. They are kicked out of that plan even if they want it. They have to go into one of the private plans again. Then that can be repeated over and over again. Each time private insurance companies decide to pull out of an area, the seniors then can get into a Medicare fallback, but when private companies come into the service area again, they are removed from the Medicare Program and have to go back to one of the plans. It is confusing, uncertain, unfair. It is the yo-yo effect, what others call the revolving door. It is a real problem with this plan. We ought to give much more certainty to that.

Another problem identified is the so-called donut hole problem. We have heard quite a bit about that problem where once a senior is told her drug spending reaches $4,500 for a year, she will have to pay 100 percent of the costs of the prescriptions until the total drug spending reaches $5,800. Now, premiums will continue to be paid during that period, but the gap in coverage will be there, so from $4,500 to $5,800. There is not a 50/50 deal between the plan and the senior; it is 100 percent burden of the senior during that period. That is a real gap in coverage. That is a gaping hole in coverage. I don't know of any other insurance program that is so unfairly structured. That is another problem which has been identified. There have been efforts made to correct that, without success.

Another problem identified is that the private insurance plans that may come into a service area do not have a cap on the premium; it is an unlimited premium. That is a problem which has been identified. The effort to put a cap on the premiums has failed.

But of all the flaws that have been identified, the weaknesses in this program, the one that troubles me most and that troubled seniors most is the fact that it has been estimated by the CBO and by the Health and Human Services folks who operate Medicare that 37 percent of current retirees who have a prescription drug program through their former employer are going to lose their prescription drug benefit following the enactment of the plan before the Senate; that is, a situation where we are actually going to see 37 percent of our seniors—that is the estimate—who currently have a benefit being worse off as a result of what we do.

There is a debate here as to whether the plan before the Senate is going to be good for seniors because of the donut hole or because of the fact there is no cap on premiums or because of this yo-yo effect, this revolving door effect. Is it a good plan? Is it not a good plan? Will seniors who don't have health insurance, a prescription drug program now, actually want to opt into this program? That people can debate. But, at a minimum, we should do no harm. At a minimum, we should not have millions of seniors who will lose an existing prescription drug program as a result of our enacting a plan. That is the time bomb in the bill before the Senate. We should not leave people worse off than they otherwise would be.

During the markup of this bill, we had some experts who testified. One was Tom Scully, Administrator of the Centers for Medicare and Medicaid Services at HHS:

Among employees who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped.

A little later on, page 6 of the transcript of the markup of the Finance Committee:

TOM SCULLY: Thirty-seven percent of those retirees who have employer-sponsored coverage . . . [will lose their coverage].

Then, a little later on in the markup of the Finance Committee, Senator CONRAD was going to ask a question of Mr. Holtz-Eakin, our CBO Director, about this issue, and the majority leader posed a question.

Senator FRIST: Senator CONRAD, could I—on that last—I'm over here—on this employers dropping it, can I just ask a follow-up question just real quick.

Senator CONRAD: Yeah. Absolutely.

Senator FRIST: You said—is it 37 percent of employers are going to drop——

TOM SCULLY: Yes.

Colleagues, Senator FRIST said something which I hope will reverberate in this Chamber.

Senator FRIST: This has huge implications.

Then the Director of the CBO said the following:

Mr. HOLTZ-EAKIN: Thirty-seven percent of employees—of retirees with such employee insurance.

Then there was a voice, unidentified by the reporter:

MALE VOICE: As I understand it, this 37 percent is the effect of our legislation.

Mr. HOLTZ-EAKIN: Correct.

Colleagues, Senator FRIST is correct. This has huge implications. And we ought to address it. The least we can do is to direct Health and Human Services to make available to designate a Medicare backup plan for the 37 percent of our current seniors who have a prescription drug program through their previous employer to make available to them the Medicare backup program so they at least know there will be a Medicare backup for them if they lose their current prescription drug program, as is projected by the Congressional Budget Office and by Health and Human Services. It seems to me that is the least we can do.

It still will be harmful because it is very unlikely for most of the people that the Medicare backup will be as good as their current prescription drug program. It is unlikely. But at least we can say, for those people, there will be a Medicare backup plan designated by HHS which will have the criteria established by HHS and the premium established by HHS. That is the least we can do for those who are going to lose their prescription drug benefit that they currently have following the enactment of this legislation.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator has 1 minute 15 seconds.

Mr. LEVIN. I reserve the remainder of my time.

I ask unanimous consent to call up amendment No. 1111.

The PRESIDING OFFICER. The amendment is pending.

Mr. LEVIN. I ask unanimous consent that my colleague from Michigan, Senator STABENOW, be listed as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEVIN. I ask unanimous consent that the excerpts from the quoted testimony be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Senator ROCKEFELLER. Okay. Actual dollars in the plan that are spent on, number one, the drug benefit itself, provider add backs and that's all I can see. I don't need the third one I've written down.

TOM SCULLY. These are figures that were in the table. We issued it to the Committee. Since this table was put together, there were some modest modifications to the drug benefit. In particular, putting the cap at $4,500.00 instead of $4,725.00. That changes the estimate on the drug benefit from $408 billion to $402 billion over ten years.

Senator ROCKEFELLER. Four hundred two?

TOM SCULLY. Four hundred two. Six billion dollars lower. And, the provider add backs are listed on pages 2 and 3—or, pages 1 and 2——

Senator ROCKEFELLER. Could you give them to me?

TOM SCULLY. There's a long list of them, and simply adding them up is not that—they interact in many ways.

Senator ROCKEFELLER. [Unintelligible].

TOM SCULLY. [Unintelligible].

Senator ROCKEFELLER. Next one is, percent of employers who drop retiree coverage. And, the number and percent of beneficiaries who will lose retiree coverage under this plan so far.

TOM SCULLY. We don't have an estimate of the number of employers. But, among employees who have employer-sponsored insurance, our estimate is consistent with 37% having their coverage dropped. Of that 37% of those who have such coverage, about 11% of beneficiaries overall.

MALE VOICE. Could you repeat that? I didn't get the—you might pull the microphone up a little closer to you.

TOM SCULLY. Thirty seven percent of those employees who have employer-sponsored coverage, it's 11% of beneficiaries overall.

Senator ROCKEFELLER. And, what percent would drop it?

TOM SCULLY. We don't know the number of employers who would drop coverage. We know the number of employees who are effected.

MALE VOICE. I thought you gave an estimate—excuse me—this is Senator Rockefeller's time, and I just want to make sure I——

TOM SCULLY. Let me repeat so it's——

MALE VOICE. Just repeat what you said.

TOM SCULLY. Underlying our estimate are that 37% of employees who have beneficiaries who have employed-sponsored insurance, retirees who have such employer-sponsored coverage, 37% will lose their coverage. And, that is 11% of total beneficiaries.

MALE VOICE. Could I also add into this, Senator Rockefeller? What we also need to know is, what percentage of the figure you said might drop—or, case would be dropped even

Or, they could drop it entirely.

In those latter two cases, they can use the additional resources to provide other kinds of employee compensation.

What we've done is examine the literature to the extent that we can find it on employer responses to the shape of compensation packages in shaping our estimate of the number that would drop.

Senator CONRAD. Okay. Let me go to something that I have found difficult to follow. And, I'd like, if I could, to have the attention of the Chairman.

Senator FRIST. Senator Conrad, could I—on that last—I'm over here—on this employers dropping it, can I just ask a follow up question just real quick.

Senator CONRAD. Yeah. Absolutely.

Senator FRIST. You said—is it 37% of employers are going to drop——

TOM SCULLY. Yes.

Senator FRIST. This has huge implications.

Mr. HOLTZ-EAKIN. Thirty seven percent of employees—of retirees with such employee insurance.

Senator FRIST. Okay.

Mr. HOLTZ-EAKIN. And, that's 11% of overall Medicare beneficiaries.

MALE VOICE. Okay. If we did nothing, how many would be dropped over the next ten years? If you look at these curves, the employees—yours are getting out of the business, anyway—not out of the business, but the curve is going down.

What would it be ten years from now?

Mr. HOLTZ-EAKIN. We don't have an estimate of that. We isolated our estimate on the impact of the bill above the baseline. That's a question about the baseline estimate, and I don't have that.

MALE VOICE. Okay.

MALE VOICE. It's 37%, just so we're clear with each other. As I understand it, this 37% is the effect of our legislation.

Mr. HOLTZ-EAKIN. Correct.

MALE VOICE. I think the question Senator Frist has is, in your baseline you have an assumption that there will be changes, though, correct? Or, don't you?

Mr. HOLTZ-EAKIN. No, we do not.

MALE VOICE. And, would you suggest that that's an inaccurate baseline?

Mr. HOLTZ-EAKIN. In reality——

MALE VOICE. Its reality is not that. And, I can have a few of my retirees in Pennsylvania give you a call if you have any questions on that subject.

I mean, I think that's an unfair—I mean, baselines are supposed to be real, but not supposed to be artificial. That's artificial.

Mr. HOLTZ-EAKIN. The baseline issue that we—that is most important, that we capture is new retirees not having such coverage.

This is a provision that would induce existing retirees who have such coverage to have their coverage dropped or modified by the their employer.

MALE VOICE. I understand what this provision does. I just want you—I just want an understanding of what would happen without this being calculated into the baseline.

MALE VOICE. Senator Santorum, we've looked at the literature and the surveys of the employee benefits consultants of retiree offerings.

What we understand is mainly happening is that, for current workers who are newly hired, they are—employers are no longer putting as part of their compensation package a guarantee of retiree healthcare.

As far as we can tell, the base of people who are near retirement or retired are not having their healthcare—there's not that much erosion going on.

MALE VOICE. I'll have the people from Bethlehem Steel and about seven other steel companies in Pennsylvania that I can just think of off the top of my head give you a call, and let you know that their retiree health benefits have been eliminated. I mean, it's happening all over the place.

Senator Rockefeller, would you like to join into this? I mean—so, I just—I think you need to look at your baseline, please.

And, then give us an understanding of maybe looking back over the last few years and projecting forward given the trends what—how the baseline would be affected. And, I think that would much—be a much fairer score as to what the impact of this bill would be.

Senator CONRAD. Mr. Chairman?

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Let me just say that I agree entirely with Senator Santorum. We know that people are dropping—employers are dropping their plans.

And, I understand your answer to this question is the effect of this bill.

I think one of the things we've got to do—Senator Frist said it well—this has got major implications; 37% having their healthcare plans dropped. That means it's going from being on the company's nickel to being on our nickel; that dramatically increases the cost.

So, if we can find ways to hold that number down, that's in our interest and we should pursue it.

Let me go——

Mr. HOLTZ-EAKIN. If we could, before we——

Senator CONRAD. Yes, sir.

Mr. HOLTZ-EAKIN. I understand the policy interest, and * * *.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I am very proud to be joining with my colleague on this very critical amendment. Can you imagine, you are someone who has worked hard all of your life, you have been fortunate enough to have a good-paying job with benefits, you are now retired and you are fortunate to have good health benefits and you find yourself in a situation that, as a result of an action taken here—and certainly there is an effort to move forward and provide people with prescription drug coverage—but if those who already have coverage find, as a result of an action we take, there is an incentive for their employer to drop their coverage, how would you feel about that?

I know how I would feel about that. This amendment is about making sure those who have worked hard all of their lives, who have retired and have had the confidence and the security to know that those health care benefits, retirement benefits they have worked so hard to have in their retirement, would be secure—to make sure if someone is covered right now for prescription drugs that he or she not lose the ability to continue, at least to know that if their employer changes their benefit, they would have immediately the security of the backup Medicare prescription drug plan.

This is very critical in a State such as Michigan where we have 37 percent of our retirees who have insurance, who right now are fortunate enough to have health care insurance and prescription drug coverage.

While there are positives in this bill so there are those who will receive help as a result of being low-income seniors, or those with very high prescription drug costs who will receive help under this bill, one of the glaring omissions and great concerns that I have relates to what Senator LEVIN was just speaking about, the unfairness of saying to a group of people who have been fortunate enough to have insurance and prescription drug coverage that, as a result of something done by the Congress, they would potentially lose that coverage. That makes absolutely no sense.

What our amendment is saying is if, in fact, their employer would have the incentive to change or drop their coverage, they should be guaranteed that something else is right there, that Medicare as a backup should be there.

My preference would be that we change the formulas so there is not the incentive to drop anyone. That was one of the reasons I strongly supported Senator ROCKEFELLER's amendment and other amendments that have been on the floor. Because my first choice is we take away any incentive for anyone to lose their prescription drug coverage. But unfortunately those amendments were not successful. We did not have the support to do that here.

Given that, we are now coming in and saying if, in fact, an employer, because of the incentives, makes a determination to drop coverage, that at a minimum, out of a sense of decency and fairness, at a minimum that retiree needs to know that Medicare prescription drug coverage, through Medicare, is available without wading through tons of insurance forms or picking through plans or going through all the ups and downs that have been described so many times in this Chamber. They need to know, after having coverage, having it available, having it dependable, that another plan is right there for them. That is the least we can do.

I hope we will join together in a bipartisan way this evening to agree to this very important amendment, and let us send a message to those fortunate enough to have health care insurance and prescription drug coverage that we remember them, we care about them, and we are going to make sure no harm is done to them in the process of putting together this prescription drug plan.

I yield the floor.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, this is the greatest and most prosperous Nation in history. Nobody has worked harder to make this country great than our senior citizens. And few things weigh more heavily on their minds than the soaring cost of prescription drugs.

You would think such a great, prosperous Nation would honor its elders, by making sure they get the medicines they need. That is why a comprehensive, meaningful and voluntary drug benefit for our senior citizens has been among my highest priorities.

Over the last several weeks, this Senate has worked hard to achieve that. In the process, many of us who shared that goal have disagreed about how to react it. In the end, we wound up with a bill that is not how I would have created a prescription drug benefit. But it is a start.

I am voting for this bill, because I believe some benefit is better than none. I am voting for it because of people like Shirley Rosamond of Sparks, NV. Shirley, who is 78 years old, raised eight children in the Sierra Nevada. She currently spends $400 a month on medicine, and has less than $400 left over to live on. This bill would reduce her monthly costs to less than $20 in medicine. And it would provide a similar level of assistance for tens of thousands of Nevada seniors.

I am voting for this bill in the hope it will be like the camel's nose under the tent—a foot in the door for our senior citizens.

I'm hoping we will pass this bill today, and then improve it in the future. And, yes, there is plenty of room for improvement.

For example,this bill will do little to help seniors whose income is $15,000 a year or more. Even if they spend more than $100 a month on prescription drugs. That is why I voted to make the program more generous.

This bill doesn't take effect soon enough. That is why I voted for and cosponsored the Lautenberg amendment to move the start date up to 2004, instead of 2006.

There are gaps in the coverage this bill provides. That is why I voted for Senator Boxers' amendment to close the coverage gap, and Senator Graham's amendment to cancel premiums while coverage is suspended.

There were other amendments that were very good but were not agreed to. Finally, this plan is just plain confusing—which means it won't give our senior citizens the peace of mind they deserve.

I voted to address all of these issues. I wish we had succeeded, and that this bill would provide the kind of coverage our senior citizens need. We didn't and it doesn't.

We have to be honest with our senior citizens, and with the American people. This isn't the best we can do for our senior citizens, but it is the best we can do tonight.

I will vote for this bill today, because it provides a start toward fulfilling our promise to senior citizens. It a start, and I won't stop fighting until we finish the job.

The PRESIDING OFFICER. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I know we are waiting for some completion on negotiations on an amendment. As I understand it, no one is seeking recognition to continue work on other amendments. So I will speak for a couple of minutes until somebody is prepared to come to the floor to continue our work. I don't want to delay the business of the Senate but I want to express myself, as the distinguished Democratic whip has been doing with regard to the legislation.

I, too, intend to support this bill. I am thinking of the old joke about a camel being a horse designed by a committee. Oftentimes, I think of that as we work our will on legislation. In many respects, this is the legislative version of a committee horse, a camel.

It is not the kind of bill I would write. It is not the kind of bill I would cosponsor. It is not the kind of bill I would enthusiastically endorse.

I look at some of the concerns we have about this legislation—concerns about an unlimited volatility in the premium, uncertainty about the benefit package, uncertainty with regard to the deductible, uncertainty with regard to the backup, uncertainty with regard to the way the provisions can be provided in rural areas. There are many issues. Mostly I think there is far greater confusion than there is understanding with regard to the benefits themselves as seniors attempt to determine whether they will be assisted by this bill.

The confusion and the uncertainty will be issues that we have to address at some later date. But having said that, I must say that the rural provisions—the effort made by our two distinguished managers to address the rural needs to overcome the inequities that exist today—alone merit consideration and I would suggest support for this legislation. The help for low-income seniors—tens of thousands of South Dakotans will get help they are not getting today in part because of this bill. The possibility that seniors could access generic drugs with far more regularly and successfully, and the possibility that we could reimport drugs at a lower price from Canada, all are reasons why I think this bill merits our support.

As I look to the balance and look to all of those things I wish were better, my response is that we are going to make them better. It may take months, if not years, but we are going to continue to work to make this a better bill and a better program.

There are so many ways that I hope we as Senators—Republican and Democrat—can work together to make this a better bill in future years.

There is a warning and a hope as we complete our debate tonight. The warning is that if this legislation comes back from conference in a significantly different form we will not be in the same position we are tonight. This bill will enjoy broad bipartisan support tonight. But if we fail, if we endorse a bill with some of the provisions of the House, then I daresay this legislation may still be in trouble.

My hope is that we can do what I have just suggested—that over the course of the next several years we can take a very close look at ways to make this legislation better and that we can address what I would consider to be serious shortfalls, especially the benefits shutdown that exists after a person pays $4,500. We are talking about a sickness penalty that, frankly, cannot be sustained. We have to find a way to address that serious shortcoming in this legislation. I hope it is done sooner rather than later.

I come to the floor with my gratitude for the work that has been done. This is the fifth year we have made an effort to pass meaningful prescription drug legislation. We can wait no longer. We simply can't allow the perfect to be the enemy of the good. We have to take what we can do and move to build upon something that we will do in future years to make it more meaningful, make it a better piece of legislation, and make it a law that we can be enthusiastic about someday.

I vote tonight with that expectation and that hope. I am hopeful that there will be many on both sides of the aisle who will share that perspective and that expectation.

I yield the floor.

Mr. FRIST. Mr. President, I ask unanimous consent that at 9:15 tonight the Senate proceed to a vote in relation to the Levin amendment, No. 1111, to be followed by a vote in relation to the Hagel-Ensign amendment, No. 1026, with no second degrees in order to the amendments prior to the votes and with 2 minutes of debate equally divided prior to each vote.

I further ask unanimous consent that prior to the vote Senator ENSIGN be recognized for up to 15 minutes and Senator HAGEL, for up to 10 minutes, and the two managers be given up to 5 minutes each; further, that it be in order for the Hagel-Ensign amendment to be modified up to the beginning of the stacked votes.

The PRESIDING OFFICER. Is there objection?

Mr. DASCHLE. Mr. President, reserving the right to object, I suggest that we make them perhaps 10-minute votes as well to expedite our votes.

Mr. FRIST. Mr. President, let us make it 10-minute votes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Nevada.

AMENDMENT NO. 1026

Mr. ENSIGN. Mr. President, I rise to speak on behalf of the amendment on which Senator HAGEL and I have been working actually for the last several years. This amendment received bipartisan support in the last Congress as a

stand-alone bill. We actually made some improvements to it. We think if this amendment is adopted, it will dramatically improve what the committee has attempted to do to add a prescription drug benefit to Medicare. The only portion of the bill we are modifying in substantial form is the prescription drug part of it.

Let me talk about what our amendment exactly does. It would say to a person who is below 200 percent of poverty, they would pay the first $1,500 out of pocket. After that, the Government is going to pay for the rest of their drug costs, other than a 10-percent copay the person would pay.

However, if a person is up to 160 percent of poverty, we will give them, in a pharmaceutical benefit account, $500 per year, which they can use to go to a local pharmacy to buy their prescription drugs or they can use that money and negotiate the price of their prescription drugs through a pharmaceutical benefit manager and mass buy them with their drug discount card. If they want to use their local pharmacist, they can do that. And this $500, if they did not spend it that year, would be rolled over to the next year where it would cover the first part of their deductible. So if you are below 160 percent of poverty, the most you are going to pay out of pocket is less than $100 per month.

There are several benefits to our plan. First of all, with the committee mark, you pay a monthly premium of $35. You also have a deductible of $275. With our bill, you have no monthly premiums, you have a one-time annual fee of $25, and for low-income people, we waive that.

Our plan is completely voluntary. It also gives the most help to lower income seniors and gives progressively less help the more money you make.

So between 200 percent and 400 percent of poverty, $3,500 is your out-of-pocket expenses. Above that amount, the Government pays 90 percent. And from 400 percent to 600 percent of poverty, $5,500 is your out-of-pocket expenses. Above that amount, 20 percent is your deductible before catastrophic coverage kicks in.

For all of these people, though, who want to sign up for the plan, they get a drug discount card where they will save between 25 to 40 percent on their prescription drug costs. It is a completely voluntary program. And in this program, we have several benefits that we think are better than the committee's underlying bill.

One is, under our bill, States that have already enacted programs will be encouraged to keep their programs. Under the committee mark, every State that has a program for low-income seniors is going to drop those. There is no debate about that. As a matter of fact, the Secretary of HHS was before us. The person who oversees Medicare was before us. Both of them said there is nothing in this bill that will say to the States: Don't drop your plans. And they agreed they will probably drop their plans.

Our bill works with the States that have those programs, States such as my State of Nevada, and encourages those programs to be kept.

A couple of other advantages that our bill has: I want to illustrate those with a couple of examples. These are real-life cases. This is a fictitious name, of course, to protect this woman's identity, but this is a real person. We call her Doris Jones. She is 75 years old. She has an income of about $17,000 a year. She is being treated for diabetes, hypertension, and high cholesterol. She is taking medications that are very typical of what this type of a disease management would require. Her out-of-pocket expenses right now are $3,648.

Let's compare how our amendment, the Hagel-Ensign approach, would affect her out-of-pocket expenses versus the bill on the floor if our amendment is not accepted.

Under our bill, she would have $1,700 out-of-pocket expenses a year. Under the committee bill that is before us today, she would have $2,383 a year. So it is a savings of almost $700 under our approach.

Another person: James is 68 years old. He has an income of about $16,000 a year. He is being treated for diabetes, a pretty severe case of diabetes, and he has all these different medications—very common medications today for a diabetic. His total out-of-pocket expenses today are $5,700.

How does he compare under the two provisions?

Under the Hagel-Ensign approach, about $1,900 would be his out-of-pocket expenses for the year; under the bill that is before us today, a little over $4,000 in out-of-pocket expenses a year. So the difference is almost $2,200 to this senior who is sick. And we certainly would not call him a rich person. I would call this person certainly a low- to moderate-income senior.

Now, Betty is another example. These are real-life examples taking real medicine, prescribed by real doctors. She is 66 years old. She has an income of $15,500. She is being treated for breast cancer and she is taking commonly prescribed medications for that. She is on low-dose radiation. She pays about $8,000 for her prescription drugs a year.

What would happen to her under the two different scenarios?

Under our scenario, she would pay about $2,100 out of pocket. Under the bill that is before us today, she would pay $4,300.

What we have done with our amendment is we have said: Let's help the seniors who need it the most. And we put the dollars to them. Under our amendment, people who are sick, with low and moderate income, they really get help. For people above that, they are treated about the same between our amendment and the bill. The out-of-pocket expenses for people between 200 and 400 percent of poverty are about the same.

When you start getting to the wealthier seniors, there is no question, the committee bill is more generous. For very low income seniors, the committee bill is slightly more generous. But for those who are really sick, our amendment is much better.

Also, there are a couple of other advantages.

In the future, to control costs, our amendment says: The person receiving the medication has something at stake. They are paying out of their own pocket for the first dollars, so they are going to shop. They are going to go around and see: Do I need generics? First of all, do I need the drug? Could I take a generic, which may be less expensive? Are there perhaps other alternatives for treatment that may be cheaper and just as effective? They will have that conversation with their doctor because they have something at stake.

I would argue that what the committee is doing—and I applaud what they are doing, trying in a bipartisan fashion—I believe our amendment would strengthen the committee's bill dramatically because it would target the dollars, those precious taxpayers' dollars, to the people who need it the most. It will also, though, in the future, control costs and, therefore, be more responsible to the next generation.

The committee mark, especially for very low income people, pays 97.5 percent of their drug costs, maybe a $1 to $2 copay. Well, there is going to be a tremendous amount of overutilization in that group.

Our amendment gives that group help by putting $500 of their first costs into an account. They will use that to go shop because if they do not use it, it gets rolled over to the next year where it covers more of their deductible. So they have something to benefit by if they do not use it.

So I implore our colleagues to look and compare. If you look and compare, you will see there truly is a difference.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I commend Senator HAGEL and Senator ENSIGN because they have been working very carefully over the last few years to help move this process along. They have had a different approach than I have had. I have had what I call a comprehensive, universal, voluntary approach. They have

had one that is more targeted toward low-income people and toward catastrophic. We deal with that in our legislation, but we are very comprehensive. We are very universal. I don't attack their attempt, but it is just not as good as what is before the Senate. S. 1 already reflects the influence of their plan by providing a drug discount card which will give seniors access to discounted drug prices.

I would like to point out a few things. The Hagel-Ensign plan has two laudable objectives: to protect seniors against catastrophic costs and to ensure that low-income seniors are fully protected.

I am happy to report that S. 1 already meets these goals. S. 1 provides a generous protection for low-income beneficiaries, very generous. It also covers fully 90 percent of beneficiaries' out-of-pocket costs beyond $3,700. Most seniors don't have catastrophic drug costs and thus would not see any benefit from the coverage in the Hagel-Ensign plan. S. 1, on the other hand, would provide a significant basic benefit to most seniors each year. Passing a drug bill that most seniors would see no benefit from is a prescription for disaster. I am afraid of that.

So S. 1 already meets the main goals of the Hagel-Ensign plan, but it provides additional value to a much broader group of beneficiaries as well, the underlying bill, the one that they amend, the one they would decimate.

Another thing S. 1 does very well is use competition to maximize value to the taxpayers. There has been some concern that S. 1 doesn't have as much competitive reform as many of us would have preferred. But the Hagel-Ensign plan has far less reform and is much more government run.

I would like to explain: First, this amendment would rule out any true competition in the delivery of Medicare drug benefits. S. 1 would let private drug plans assume a modest amount of financial risk, giving them an incentive to drive hard bargains and keep taxpayers' costs down. It seems to me that is very significant—the difference between the underlying bill and their bill. We are going to drive drug prices down more through competition.

The Hagel-Ensign plan, it is pretty obvious from my point of view, allows for no such exemption, specifically mandating that the Government—in this case we are talking about the taxpayers—bears all the financial risk for delivering the benefit, much as Senator BOB GRAHAM's did the last year when we debated this very issue.

Under this amendment, the benefit would be delivered just like other Medicare benefits are today—by contractors that merely pay the claims that come in without any effort whatsoever, no effort to contain costs.

Second, the Hagel amendment doesn't include any of the improvements to the Medicare Program that President Bush has proposed and our bill includes. It does not include the role for private preferred provider organization plans to deliver an improved Medicare benefit package. It doesn't make modern innovations such as disease management services or rational cost sharing available to beneficiaries who choose them. It simply dumps a catastrophic drug benefit on to the 1965 vintage Medicare system.

What the people of this country need is improvement in Medicare, strengthening of Medicare, voluntary, universal, comprehensive. The Ensign plan wouldn't improve S. 1, but it would make it substantially worse.

I urge my colleagues to defeat the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I want to clear up something. We don't touch any of the other Medicare reforms in your bill. The whole thing with the PPOs, we touch the prescription drug part of the underlying bill.

You mentioned competition. I practiced veterinary medicine, built, owned, and operated two different animal hospitals. Why do I bring that up? It is because in veterinary medicine people pay out of their own pocket. Veterinarians are in an incredibly competitive field because we know that if somebody brings a case to you, they are going to shop about half the time based on price. So veterinarians have to be very competitive and price sensitive to that, so they work to become more efficient, to keep their costs down, because individuals shop.

In our health care system today, individuals do not shop because we have low deductible policies, and a lot of times the doctors waive those deductibles. Senator FRIST will be able to tell you about that. The hospitals waive the deductibles. So the person receiving the care is not accountable for the care, and so they don't shop. The doctor tells them, go get this service or this drug, and they don't think about it. They have modest, low copays, and they don't think about it.

The cost control, the competition, is established by 40 million people on Medicare, 40 million people receiving drugs. If they are paying out of their own pocket or low-income people have the $500 in a pharmaceutical benefit account, they have something at stake, so they go shop.

They ask the questions: Do I need the drug in the first place? Maybe I can get a generic. So they do the shopping. Also, we have pharmaceutical benefit managers in the bill. That is what the whole drug discount card is about. So those pharmaceutical benefit managers help lower the costs as well.

We have several reforms in this bill that are true reforms, that introduce competition to keep the costs down. That is why our bill actually scored lower.

Because of that, we were able to add a couple other things. When Senator HAGEL arrives, he will modify the amendment. For instance, we will allow Medicaid, the dual eligibles that people have been talking about today, to give States help in handling those dual eligibles through Medicare because our prescription drug cost to the taxpayer was less. It is because we have more reform on the prescription drug part of it than the underlying bill. It just a difference of philosophy of how you do it.

I come to this based on my experience in the private sector and how health care can be delivered by individuals shopping.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time be equally charged.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HAGEL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HAGEL. Mr. President, in the last 2 weeks the Senate has engaged in an historic effort to reform and strengthen Medicare. When we opened this debate 2 weeks ago, I said that what we would do here debating this bill would affect every American and future generations.

Health care is a defining issue for our Nation and future generations. Just a reminder: When Medicare was enacted in 1965, the Federal Government's lead actuary at that time projected that the hospital program, Medicare Part A, would grow to $9 billion by 1990. In fact, the program, in 1990, had then cost the taxpayers $66 billion. So we have some sense of how these programs can get out of hand if not defined clearly at the front end.

In addition to the internal problems of the changing realities of health care, Medicare is facing a looming external problem. The largest generation in American history, the baby boomers, are aging. These Americans—over 75 million of them—will be added to the Medicare rolls over the next few years. The baby boom generation has changed and shaped every market it has ever entered. Medicare will be no exception. We have a responsibility to address this demographic pressure now or risk the system collapsing under its own weight in the future.

Senator ENSIGN and I have come to the floor to offer an amendment to substitute only title I of the Finance Committee's bill, providing a prescription drug benefit for seniors. We believe any Medicare drug benefit must be sustainable for future generations. The benefit must deal with the realities that people are living longer and better and have higher health care expectations than ever before. We believe we can do better with our amendment.

Our amendment is a simple amendment. Seniors will be able to understand it clearly. Unlike the underlying bill, our amendment contains no premiums, no deductibles, and no gaps in coverage. Our modified amendment addresses three of the major issues we have tried to deal with in constructing this plan. First, it helps low-income seniors, those who need it the most. Two, it protects seniors from high out-of-pocket expenses, and it eases the burden prescription drug costs have placed on the States.

Our modified amendment would replace the prescription drug benefit in the Finance Committee plan with, No. 1, a prescription drug discount card for all seniors on Medicare with $30 billion in added funds for low-income seniors; No. 2, catastrophic coverage for all seniors; No. 3, $35 billion in cost-sharing for catastrophic drug costs with the States for the lowest income seniors eligible for both Medicare and Medicaid.

We give the Secretary of Health and Human Services the discretion to divide $65 billion for seniors and for help with drug costs at the State level. With our amendment, the Secretary will provide low-income seniors with money on a drug discount card to help defray their drug expenses.

States would also benefit under our amendment, and $35 billion is available to help States cover the catastrophic drug expenses for the dual eligibles. These are the very poorest of seniors.

These modifications to the amendment make it stronger by targeting aid to those who need it the most. This bill has been scored. We fall within the $400 billion budget number that is required.

This is a commonsense plan that is workable and responsible, and it addresses prescription drug concerns in the right way.

AMENDMENT NO. 1026, AS MODIFIED

Mr. HAGEL. Mr. President, I have a modification at the desk to amendment No. 1026. I ask unanimous consent that the amendment be modified.

The PRESIDING OFFICER. The amendment is so modified.

The amendment (No. 1026), as modified, is as follows:

TITLE I—MEDICARE PRESCRIPTION DRUG DISCOUNT

SEC. 101. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D(a)(4)(B).

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered drug—

''(i) for which payment would not be made if section 1862(a) applied to part D; or

''(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D(a)(4).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

''(A) eligible for benefits under part A or enrolled under part B; and

''(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

''(A) pharmaceutical benefit management company;

''(B) wholesale pharmacy delivery system;

''(C) retail pharmacy delivery system;

''(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

''(E) Medicare+Choice organization;

''(F) State (in conjunction with a pharmaceutical benefit management company);

''(G) employer-sponsored plan;

''(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

''(I) combination of the entities described in subparagraphs (A) through (H).

''(4) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

''ESTABLISHMENT OF PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

''(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

''(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

''(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

''(c) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''ENROLLMENT

''SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

''(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

''(2) ENROLLMENT PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

''(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

''(C) OPEN ENROLLMENT PERIOD IN 2005 FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

''(i) enroll under this part; or

''(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

''(3) PERIOD OF COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

''(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(4) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

''(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual's coverage under this part if the individual is—

''(i) no longer enrolled in part A or B; or

''(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

''(i) the termination of coverage under part A or (if later) under part B; or

''(ii) the coverage under title XIX.

''(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

''(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

''(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

''(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

''(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

''(3) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

''(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICARE+CHOICE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a Medicare+Choice plan.

''(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(F) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

''(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

''PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

''SEC. 1860C. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

''(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860B(c).

''ENROLLEE PROTECTIONS

''SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

''(1) GUARANTEED ISSUANCE AND NONDISCRIMINATION.—

''(A) GUARANTEED ISSUANCE.—

''(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(ii) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

''(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(2) DISCLOSURE OF INFORMATION.—

''(A) INFORMATION.—

''(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

''(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

''(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

''(II) How any formulary used by the eligible entity functions.

''(III) Information on grievance and appeals procedures.

''(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

''(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

''(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the

information described in paragraph (3) to such beneficiary.

''(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

''(3) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

''(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(4) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

''(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

''(1) ACCESS TO COVERED BENEFITS.—

''(A) ASSURING PHARMACY ACCESS.—

''(i) IN GENERAL.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(a)(3) that ensure such convenient access.

''(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

''(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

''(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860F(b).

''(B) USE OF STANDARDIZED TECHNOLOGY.—

''(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860F(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

''(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

''(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

''(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

''(ii) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(iii) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

''(iv) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(v) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860D(a).

''(2) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

''(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

''(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

''(iii) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

''(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(ii) ELEMENTS.—Such program may include—

''(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(III) detection of patterns of overuse and underuse of prescription drugs.

''(iii) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

''(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(C) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

''(ii) Subsection (c)(1) (relating to access to covered benefits).

''(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug covered under the plan that is therapeutically equivalent and bioequivalent.

''ANNUAL ENROLLMENT FEE

''SEC. 1860E. (a) AMOUNT.—

''(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment.

''(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

''(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

''(ii) such aggregate expenditures for the 12-month period ending with July 2005.

''(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

''(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

''(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

''(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

''BENEFITS UNDER THE PROGRAM

''SEC. 1860F. (a) ACCESS TO NEGOTIATED PRICES.—

''(1) NEGOTIATED PRICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term 'prescription drugs' is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

''(B) LIMITATIONS.—

''(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

''(2) DISCOUNT CARD.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

''(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

''(b) CATASTROPHIC BENEFIT.—

''(1) TEN PERCENT COST-SHARING.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

''(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

''(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as determined under section 1860I) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

''(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to $3,500.

''(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to $5,500.

''(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary's income for that year (rounded to the nearest multiple of $1).

''(3) APPLICATION.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

''(4) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year after 2006, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

''(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

''(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

''(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

''(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

''REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

''SEC. 1860G. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

''(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(c) ADMINISTRATIVE FEE BID.—

''(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

''(2) BID SUBMISSION REQUIREMENTS.—

''(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

''(i) Enrollment, including income eligibility determination.

''(ii) Claims processing.

''(iii) Quality assurance, including drug utilization review.

''(iv) Beneficiary and pharmacy customer service.

''(v) Coordination of benefits.

''(vi) Fraud and abuse prevention.

''(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

''(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

''(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

''(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

''(d) AWARDING OF CONTRACTS.—

''(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

''(2) TERMS AND CONDITIONS.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

''(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

''(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

''(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

''(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

''(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

''(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

''(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

''(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

''(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

''(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

''(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

''PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

''SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

''(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860F(b); and

''(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

''(b) PAYMENT FOR COVERED DRUGS.—

''(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860F(b).

''(2) LIMITATIONS.—

''(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(B).

''(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a) or the price negotiated for insurance coverage under the Medicare+Choice program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

''(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

''(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

''(c) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''DETERMINATION OF INCOME LEVELS

''SEC. 1860I. (a) DETERMINATION OF INCOME LEVELS.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E(c) and 1860F(b).

''(2) PROCEDURES.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

''(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

''(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E(c) and 1860F(b); and

''(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

''(c) QUALITY CONTROL SYSTEM.—

''(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

''(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

''APPROPRIATIONS

''SEC. 1860J. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E.

''MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

''SEC. 1860K. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the 'Board').

''(b) ADVICE ON POLICIES; REPORTS.—

''(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

''(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

''(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

''(A) PRESIDENTIAL APPOINTMENTS.—

''(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

''(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

''(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

''(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

''(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(3) COMPOSITION.—Of the members appointed under paragraph (1)—

''(A) at least 1 shall represent the pharmaceutical industry;

''(B) at least 1 shall represent physicians;

''(C) at least 1 shall represent medicare beneficiaries;

''(D) at least 1 shall represent practicing pharmacists; and

''(E) at least 1 shall represent eligible entities.

''(d) TERMS OF APPOINTMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

''(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

''(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

''(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

''(I) 2 years;

''(II) 4 years; and

''(III) 6 years.

''(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

''(I) 3 years; and

''(II) 6 years.

''(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

''(I) 4 years; and

''(II) 5 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

''(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

''(g) MEETINGS.—

''(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

''(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

''(i) PERSONNEL.—

''(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(2) STAFF.—

''(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

''(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 101).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part D.''.

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

''(1) PROMULGATION OF MODEL REGULATION.—

''(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of

Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

''(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

''(ii) a uniform format is used in the policy with respect to such revised benefits; and

''(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2006 NAIC Model Regulation').

''(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2006 Federal Regulation').

''(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

''(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

''(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

''(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

''(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

''(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

''(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.''.

SEC. __. PARTIAL FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR CATASTROPHIC COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1): is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(d)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

''(d) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

''(A) MEDICARE BENEFITS FOR MEDICAID ELIGIBLES.—The total amount of payments made in the quarter because of the operation of section 1845 that are attributable to individuals who are residents of the State and are eligible for medical assistance with respect to prescription drugs under this title.

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2005 is 90 percent;

''(B) a subsequent year before 2014, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

''(C) a year after 2013 is 0 percent.''.

(3) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(e) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to benefits under part B of title XVIII and is eligible for medical assistance with respect to prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under such part B, without regard to section 1902(n)(2).''.

(4) LIMITATION AND CAPS.—The Secretary will implement the above section to the extent possible within a total federal authorization of $35,000,000,000.

SEC. __. ADDITION OF DOLLAR AMOUNT TO PRESCRIPTION DRUG DISCOUNT CARDS; EFFECTIVE DATE.

(a) ADDITION OF DOLLAR AMOUNTS TO PRESCRIPTION DRUG DISCOUNT CARDS.—Section 1860F (as added by section 101) is amended by adding at the end the following:

''(c) PROVISION OF DOLLAR AMOUNTS ON CARDS.—

''(1) AMOUNT OF ANNUAL ASSISTANCE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, each eligible entity with a contract under this section shall provide coverage for the applicable amount of expenses for prescription drugs incurred during each calendar year by an eligible beneficiary enrolled in a prescription drug discount card plan offered by such entity.

''(B) APPLICABLE AMOUNT DEFINED.—For purposes of subparagraph (A), the term 'applicable amount' means the total amount that the Secretary determines will not cause expenditures under this part to exceed the total amount that would have been expended under this title if this part had not been enacted by more than $30,000,000,000 during the period beginning on January 1, 2005, and ending on September 30, 2010.

''(2) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible beneficiary is not enrolled in a prescription drug discount card plan offered by an eligible entity with a contract under this part, the amount of assistance available under paragraph (1) shall be reduced by $50.

''(3) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—

''(A) IN GENERAL.—The dollar amount of coverage described in paragraph (1) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

''(B) REFUND OF EXCESS AMOUNTS.—The Administrator shall refund to the eligible beneficiary the amount (if any) by which the dollar amount of coverage described in subparagraph (A) exceeds the catastrophic limit described in subsection (b).

''(4) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Administrator may waive such requirements of this part as may be necessary to ensure that each eligible beneficiary has access to the assistance described in subparagraph (A).

''(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card plan if the program excludes the drug under a formulary and such exclusion is not successfully resolved under the grievance or appeals processes provided for under this part.

''(6) PAYMENTS TO PLANS.—The Administrator shall reimburse each eligible entity for any costs incurred under this subsection.''.

(b) EFFECTIVE DATE.—Part D is amended by adding at the end the following new section:

''EFFECTIVE DATE

''Sec. 1860L. Nothwithstanding any other provision of this part, the Voluntary Medicare Prescription Drug Discount and Security Program under this part shall apply only during the period beginning on January 1, 2005 and ending on December 31, 2010.''.

Mr. HAGEL. Mr. President, I now ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. HAGEL. I thank the Chair and yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, the prescription drug bill, Medicare reform bill combination that we have before us today, as we all know, is a freight train coming through this place and there is no stopping it.

What is very unfortunate is that we have a very legitimate amendment on

the floor today that is getting 20, 30 minutes' worth of debate. I put up some examples on the chart here of how this amendment we are offering is superior. I have tried to be objective, to say that above 200 percent of poverty, between 200 and 400 percent of poverty they are pretty equal plans. For the very low income, our amendment is slightly less generous, but it keeps the low-income people with something at stake so they will shop. We have heard nothing about that from the other side. There has been no debate, in other words. It is because there is an agreement to defeat any substantive amendment. It is unfortunate.

This is probably the most important vote, as far as an entitlement program, that any of us in our careers will ever take, and this bill is being rushed through so that we can get a ''bill'' to conference, where all of the improvements are going to be made.

We have an amendment before us that I believe should be debated. If you disagree, fine, but let's debate it and vote on it up or down. But I don't think this kind of a process is healthy for the Senate.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Mr. BREAUX. Mr. President, I yield myself whatever time we have in opposition to the amendment.

The PRESIDING OFFICER. Of whose time?

Mr. BREAUX. Off of the chairman, Senator GRASSLEY's time.

The PRESIDING OFFICER. The Senator is recognized.

Mr. BREAUX. Mr. President, I start off by commending the authors of the amendment for a real serious effort to try to improve the bill. But I rise in opposition because there is not any segment of the senior population that you could not isolate and target and say we can make, for this particular group, a better deal than they have in this bill. That is not the purpose of this legislation.

The purpose of Medicare is that it is universal. It is not a welfare bill. It is not just for low-income individuals. It is for every American citizen who has reached the age of 65, or older, and qualifies for the program. That is one of the greatest features of the Medicare Program—that everyone is essentially treated equal.

So it is easy, if you want to isolate a low-income group and say we are going to give them a better deal. But when you are looking at the entire population of almost 40 million Americans with whom we have to deal, that, indeed, is the real challenge, and that is why the content of this bill is far superior than to narrowly isolate only low-income people and say we can do a better deal for them. Of course, but you are not going to be able to do that in keeping with the general theme of what Medicare is all about and taking care of all Medicare seniors with the best possible deal.

I think that is what the goal of this Congress should be, and that is why what we have in the provisions here to give them prescription drugs, which would be within the Medicare Program, that people can voluntarily continue to accept the traditional Medicare or, if they would like, move into an expanded Medicare Advantage and get all of the benefits through a private, competitively delivered system.

What we have is the beginning of a program that can be improved upon and will be. But we have essentially an insurance-type program, similar to what we have as Federal employees, which can be improved upon. But it is for everybody. We, too, give special attention to lower income individuals, and maybe they can do it better, but it is going to have to come from somewhere else, and the somewhere else is the vast number of other seniors who would have some of their benefits diluted and reduced in order to make this a little better than what is in this bill.

The goal is to try to create a universal program across the board, and one that is fair to everyone. I think that is what is in the bill as it now stands.

Mr. GREGG. Will the Senator yield for a question?

Mr. BREAUX. Yes, I am happy to yield.

Mr. GREGG. Would the Senator agree that there wasn't, in the original program set up as an insurance program, which you would pay into during your working life under the Part A part of the insurance program, with the concept that when you retired, you would have paid for your health insurance. That is why everyone is covered under it. But is it not also true that under this drug benefit as proposed, nobody will have paid into the Medicare insurance plan for the purposes of this drug program? This drug program will be a new entitlement, and therefore it is reasonable that since it is going to be borne not by the people who worked for it but by the people who are working—it is going to be borne by them rather than the recipients—then it should be set up in a different structure along the lines that are proposed, which is you benefit the low income and you benefit people who have a catastrophic event rather than have a program that puts the benefit out to everyone and forces 37 percent of the population off private insurance plans and on to a public plan.

Mr. BREAUX. I am not sure whose time this is on. I will respond to the Senator's question. We have a health delivery system supervised by the Federal Government, and the beneficiaries are going to contribute to it. Those benefiting from it are going to have an average premium of $35 a month, a $275 deductible, and 50 percent copayment.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. BREAUX. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Parliamentary inquiry: Will the Chair inform the Senate as to the time allowable on this amendment?

The PRESIDING OFFICER. The Senator from Nebraska has 4 minutes 30 seconds remaining. No time remains in opposition.

Mr. BAUCUS. I wonder if I can get consent to speak for 1 minute on this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, two points: One, this amendment is totally new. We have not seen the language. We have been asking for the language for days. It has been filed in various forms. This is new language. The Senate has no idea what is in this amendment. We saw it for the first time maybe 15, 20, 30 minutes ago. It is impossible to know what this amendment does.

Point No. 2, essentially what we can tell by a cursory glance at the amendment is the amendment enters a whole new concept in Medicare that has not been done before, and that is means testing. It means tests those at the catastrophic levels.

I do not think we want to begin to go down that road tonight. It makes more sense to stay with the underlying bill which essentially gives a 44-percent rate to those beneficiaries with lower income.

The problem is it does not help, as our bill does, up to catastrophic, and then catastrophic is means tested. That is not the right thing to do, certainly at this hour after looking at it 30 minutes ago.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Nevada.

Mr. ENSIGN. Mr. President, I ask unanimous consent for whatever time I consume from Senator HAGEL's time to respond.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HAGEL. Mr. President, I understand I have 4 minutes 20 seconds.

The PRESIDING OFFICER. That is correct.

Mr. HAGEL. I yield to my colleague whatever time he requires from my time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENSIGN. Mr. President, means testing and universal have been mentioned. The Senator from New Hampshire mentioned that this is a brand new benefit, and that is why we are only talking about the prescription drug part—a brand new benefit for which young people in America are going to be paying for years and years. It seems to make sense that we try to control those costs.

Yes, our bill means tests. So does the underlying bill. To sit up here and say their bill does not means test is completely disingenuous. They have several levels in the low-income areas they means test. They are just means testing in a different area. If you

means test one, why is calling our bill means testing when their bill means tests as well? How can they say our bill means tests and theirs does not? That is disingenuous.

It is critical that we have this debate. There was a complaint that they just saw this amendment tonight. Part of the reason is that we are trying to rush this bill through what is supposed to be the most deliberative body in the world, and we have this false deadline that we must get this bill passed before the July break. I submit, this deserves more debate. The debate cannot happen when it goes to conference because most of the Senate is cut out then and there is no debate when it comes back here.

With all due respect, I think we have a superior portion of the prescription drug plan, and I hope our colleagues vote for this plan.

I reserve the remainder of our time.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Mr. President, how much time is remaining?

The PRESIDING OFFICER. Two and a half minutes.

Mr. HAGEL. Mr. President, in addition to what my colleague from Nevada has said in response to the distinguished Senator from Montana, there is nothing new about this bill except two features.

This bill, the Hagel-Ensign bill, last year received more bipartisan votes on the floor of this Senate than any other bill. There is nothing new in this bill except two features. One is the $30 billion for low-income seniors' additional coverage, and the other is the $35 billion in cost sharing for catastrophic drug costs with Medicare and Medicaid to dual eligibles. That is what is new in the bill.

To say this is new and we have just sprung this on the Senate is a bit disingenuous. This bill has been around for almost 4 years in its current form.

I yield the floor.

The PRESIDING OFFICER. Does the Senator yield back his time?

Mr. HAGEL. Mr. President, I yield back all of my time.

AMENDMENT NO. 1111

The PRESIDING OFFICER. There are 2 minutes evenly divided on the Levin amendment No. 1111. Who yields time on the Levin amendment No. 1111?

Mr. BAUCUS. It is my understanding the sponsor, Senator LEVIN, is in the Chamber.

Mr. LEVIN. I have already spoken on the amendment.

The PRESIDING OFFICER (Mr. ENSIGN). All time is yielded back.

The question is on agreeing to amendment No. 1111.

Mr. BAUCUS. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Oklahoma (Mr. INHOFE) are necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER (Mr. GREGG). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 42, nays 54, as follows:

[Rollcall Vote No. 259 Leg.]

YEAS—42

Akaka	Durbin	Levin
Bayh	Edwards	Lincoln
Biden	Feingold	Mikulski
Bingaman	Feinstein	Murray
Boxer	Graham (FL)	Nelson (FL)
Byrd	Harkin	Nelson (NE)
Cantwell	Hollings	Pryor
Clinton	Inouye	Reed
Conrad	Johnson	Reid
Corzine	Kennedy	Rockefeller
Daschle	Kohl	Sarbanes
Dayton	Landrieu	Schumer
Dodd	Lautenberg	Stabenow
Dorgan	Leahy	Wyden

NAYS—54

Alexander	Craig	McCain
Allard	Crapo	McConnell
Allen	DeWine	Miller
Baucus	Dole	Murkowski
Bennett	Ensign	Nickles
Bond	Enzi	Roberts
Breaux	Fitzgerald	Santorum
Brownback	Frist	Sessions
Bunning	Graham (SC)	Shelby
Burns	Grassley	Smith
Campbell	Gregg	Snowe
Carper	Hagel	Specter
Chafee	Hatch	Stevens
Chambliss	Hutchison	Sununu
Cochran	Jeffords	Talent
Coleman	Kyl	Thomas
Collins	Lott	Voinovich
Cornyn	Lugar	Warner

NOT VOTING—4

Domenici	Kerry
Inhofe	Lieberman

The amendment (No. 1111) was rejected.

Mr. LOTT. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1026, AS MODIFIED

The PRESIDING OFFICER. Before we can go to the next amendment, we will have to have order in the Senate.

There are 2 minutes equally divided. Who seeks recognition? The Senator from Nevada.

Mr. ENSIGN. Mr. President, I will use 30 seconds and Senator HAGEL will use 30 seconds on this side.

The Hagel-Ensign amendment corrects several problems in the bill. Let me go over those real briefly.

We have no monthly premiums. We do not make middle-class taxpayers pay for prescription drugs for wealthy seniors. We preserve the State and the private plans that are already out there, which the underlying bill does not do. We give most of our help to low- and moderate-income seniors but we still control costs in our bill.

I encourage a ''yes'' vote on this amendment.

Mr. HAGEL. Mr. President, to summarize our amendment is simple: It helps those who need it most. It helps the States provide a discount drug card. It is affordable, with no monthly premiums, no deductibles, catastrophic coverage, and accountable market-based tools. It is a complete, affordable, discount drug plan that the next generation of this country can support. We can be proud of what we are doing for our seniors.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the major fatal problem with this amendment is it dispenses with the underlying principle of the underlying bill. That is universality. We are, in the legislation before us, providing for universal benefits.

This amendment violates that principle by saying no, not across the board for Americans but, rather, it introduces a whole new means testing provision for catastrophic. I just think it fatally violates the spirit of the legislation we are about to pass.

The PRESIDING OFFICER. All time has expired. The question is on agreeing the amendment No. 1026, as modified. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Oklahoma (Mr. INHOFE) are necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 21, nays 75, as follows:

[Rollcall Vote No. 260 Leg.]

YEAS—21

Allard	Graham (SC)	McConnell
Brownback	Gregg	Reid
Burns	Hagel	Roberts
Chambliss	Hutchison	Santorum
Crapo	Lott	Sessions
Dole	Lugar	Sununu
Ensign	McCain	Talent

NAYS—75

Akaka	Chafee	Enzi
Alexander	Clinton	Feingold
Allen	Cochran	Feinstein
Baucus	Coleman	Fitzgerald
Bayh	Collins	Frist
Bennett	Conrad	Graham (FL)
Biden	Cornyn	Grassley
Bingaman	Corzine	Harkin
Bond	Craig	Hatch
Boxer	Daschle	Hollings
Breaux	Dayton	Inouye
Bunning	DeWine	Jeffords
Byrd	Dodd	Johnson
Campbell	Dorgan	Kennedy
Cantwell	Durbin	Kohl
Carper	Edwards	Kyl

Landrieu	Nelson (FL)	Smith
Lautenberg	Nelson (NE)	Snowe
Leahy	Nickles	Specter
Levin	Pryor	Stabenow
Lincoln	Reed	Stevens
Mikulski	Rockefeller	Thomas
Miller	Sarbanes	Voinovich
Murkowski	Schumer	Warner
Murray	Shelby	Wyden

NOT VOTING—4

Domenici	Kerry
Inhofe	Lieberman

The amendment (No. 1026), as modified, was rejected.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, for the information of Senators, we have made tremendous progress today, and we are on the final leg. In conversations with the managers, it appears we will have one more series of stacked votes tonight and that will include final passage. That series will be it. The bill will be done.

We need somewhere between 45 minutes and an hour—hopefully 45 minutes, and hopefully people can yield back their time—before we can begin those votes. I think that is all we can say at this juncture, working in good faith. There are a lot of details. We are waiting for some of the final wording to come through in terms of the managers' package. Once we have that, we will be able to proceed with the voting.

I don't know how many amendments it will be. It could be two amendments; it could be four amendments; it could be one amendment or passage. But it is going to be probably two or four amendments beginning in about 45 minutes to an hour.

Mr. BYRD. Will the leader yield?

Mr. FRIST. Yes.

Mr. BYRD. On the preceding rollcall vote, 28 minutes were required. On this rollcall vote, 22 or 23 minutes were required. So we have over 50 minutes on two rollcall votes. Now, time is worth a little something around here to many of us who don't have much time left. I wonder if we can't do better than that.

I think the Senate ought to treat itself better than that. Senators owe to it other Senators to not just lag and cause rollcall votes to last so long. Twenty-eight minutes on a rollcall vote? Why can't we go over to tomorrow? We are going to be here anyhow. Why can't we go over? Here it is 15 minutes after 10. Do I have the floor, Mr. President?

The PRESIDING OFFICER. The majority leader has the floor.

Mr. BYRD. Very well.

Mr. FRIST. Mr. President, we can do better, and I think we ought to do our best to try to do maybe 10 minutes on the last series. It is late at night. We have all been working about 12, 13 hours nonstop. It is an important bill. We set out this morning to finish tonight. People are here. They are ready to finish it. It is late. After talking to the managers and the leadership on both sides, there is a general consensus that we ought to push ahead, get this bill done for the American people.

We can do it. Things have gone very well. We have had adequate time for debate and amendment. The distinguished Senator from West Virginia told me from day one: My advice to you as the majority leader is to make sure you give time for debate and amendment. He did forget to tell me that it is sometimes hard dealing back and forth as you are waiting for language to come, as you are trying to get the order for amendments in these last hours on a very complex bill, a bill that is as big as any bill we have passed this year and as complex, and it has taken a little bit more time.

I would have liked to have finished at 9 o'clock tonight. I think at this juncture, if we proceed over the next 45 minutes—let's do those rollcall votes in 10 minutes—we will be out of here. People will be able to leave tomorrow or stay and come to the floor and talk. I think that is the general sense of where we should go.

Mr. BYRD. Mr. President, will the Senator yield?

Mr. FRIST. The Senator is happy to yield to the Senator from West Virginia.

Mr. BYRD. Mr. President, we are falling into this way of doing things. Three-day work weeks. I will tell you, Mr. Leader, one night I am going to get the floor and Senators will be planning on finishing and going home the next day. They won't get to do that. I have seen this happening over and over and over more recently. Three-day work weeks, and we don't come in on Friday and work and vote.

If the Senator will continue to yield, just briefly?

Mr. FRIST. If the Senator will yield for a couple more minutes because we do have people who want to get on to the business. I certainly do yield for a few more minutes.

Mr. BYRD. Mr. President, I don't want to overtax the leader at this point or overtax other Senators. Just suffice it to say, we had better get out of this habit of just having 3-day workweeks, staying here until 10, 11, 12 on Thursday night so that people can go out on Friday. I started this thing of having a week at home every 4 weeks, but we worked the 5 days. We worked 5 days in each of the 3 weeks in between, and we started voting early on Mondays and we voted a full day on Friday. I know things have changed. I am not majority leader. I don't mean to be a problem to the majority leader. But this is getting to be a problem with some of us.

Mr. FRIST. Mr. President, let me just reply and say: Last Friday, you and I were on the floor at 3 in the afternoon. Just because we are not voting doesn't mean we are not working. Some of us do have constituents we go back to and spend time with. Some of us are working on bills and reading. Just because we are not voting does not mean we are not working.

Mr. BYRD. I understand that.

Mr. FRIST. Again, I suggest that we go back so we can work and debate and get these two or four amendments finished. I would be happy to talk to the Senator. I understand he wants us to be efficient and work 5 days a week. I would like to work 6 days a week.

Mr. BYRD. I have a wife at home and she needs me there. I ought to be there. I have stopped early on two occasions lately just to go be with her and let the Senate run its course. There is going to come a time when this Senator is going to keep the Senate in session a while. He can still do it.

I say this in the very best of spirit to the leader—and he is doing the best he can—there comes a time when some of us have duties elsewhere and we would like to keep our rollcall records clean. Soon I will have cast 17,000 rollcall votes. So I have been here for my share of the votes. I am getting a little bit fed up staying around here. This last rollcall vote was 23 minutes and the one before that was 28 minutes. There is a lot of hooping and hollering. What do the American people think of us? It is time we went home if we don't work.

I hope, Mr. Leader, that those of you who are so good at working out these things can get people to have voice votes or maybe cut down the time on their amendments.

Mr. FRIST. Mr. President, I suggest that, since we have our colleagues here and ready to work, we go back to work now. I think the Senator made his point. I am listening and I will heed that advice and counsel. I suggest we go back to work so we can get home tonight to our families as well.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition? The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I believe we are in the process of trying to wrap up debate on a few amendments. I believe momentarily Senator FEINSTEIN and Senator CHAFEE and I will be discussing our amendment. I will make my comments very brief. I know Senator FEINSTEIN wishes to speak on it. I hope we can conclude debate. I think there will only be two more amendments. I urge colleagues to make their comments brief and let's vote and finish action on this bill. I will defer my comments on the amendment because I believe the Senator from California is ready to speak.

The PRESIDING OFFICER. The Senator from California is recognized.

AMENDMENT NO. 1060, AS MODIFIED

Mrs. FEINSTEIN. Mr. President, I call up amendment No. 1060, as modified.

The PRESIDING OFFICER. Without objection, the amendment, as modified, is now the pending business.

The amendment (No. 1060), as modified, is as follows:

At the end of title IV, insert:

Subtitle D—Part B Premium

SEC. ___. INCOME-RELATED INCREASE IN MEDICARE PART B PREMIUM.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

''(h) INCREASE IN PREMIUM FOR HIGH-INCOME BENEFICIARIES.—

''(1) AMOUNT OF INCREASE.—

''(A) IN GENERAL.—Except as provided in paragraph (4), if the modified adjusted gross income of an individual for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) exceeds the threshold amount, the amount of the premium under subsection (a) for the individual for the calendar year shall, in lieu of the amount otherwise determined under subsection (a), be equal to the applicable percentage of an amount equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for the calendar year.

''(B) APPLICABLE PERCENTAGE.—The term 'applicable percentage' means the percentage determined in accordance with the following tables:

''(i) INDIVIDUALS NOT FILING JOINT RETURNS.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $50,000	50 percent
More than $50,000 but not more than $100,000	75 percent
More than $100,000	100 percent.

''(ii) INDIVIDUALS FILING JOINT RETURNS.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $100,000	50 percent
More than $100,000 but not more than $200,000	75 percent
More than $200,000	100 percent.

''(C) DEFINITION OF THRESHOLD AMOUNT.—For purposes of this subsection, the term 'threshold amount' means—

''(i) except as provided in clause (ii), $100,000; and

''(ii) $200,000 in the case of a taxpayer filing a joint return.

''(D) INFLATION ADJUSTMENT FOR THRESHOLD AMOUNT.—

''(i) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in clause (i) of subparagraph (C) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding calendar year exceeds such average for the 12-month period ending with June 2005.

''(ii) JOINT RETURNS.—The dollar amount described in clause (ii) of subparagraph (C) for any calendar year after 2006 shall be increased to an amount equal to twice the amount in effect under clause (i) of subparagraph (C) (after application of this subparagraph).

''(iii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

''(E) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(F) JOINT RETURN.—For purposes of this subsection, the term 'joint return' has the meaning given such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

''(2) DETERMINATION OF MODIFIED ADJUSTED GROSS INCOME.—The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) NOTICE.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year. In providing such notice, the Secretary shall use the most recent poverty line available as of the date the notice is sent.

''(B) CALCULATION BASED ON INFORMATION PROVIDED BY BENEFICIARY.—If, during the 60-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with appropriate information (as determined by the Secretary) on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) CALCULATION BASED ON NOTICE AMOUNT IF NO INFORMATION IS PROVIDED BY THE BENEFICIARY OR IF THE SECRETARY DETERMINES THAT THE PROVIDED INFORMATION IN NOT APPROPRIATE.—The amount initially determined by the Secretary under this paragraph with respect to an individual shall be the amount included in the notice provided to the individual under subparagraph (A) if—

''(i) the individual does not provide the Secretary with information under subparagraph (B); or

''(ii) the Secretary determines that the information provided by the individual to the Secretary under such subparagraph in not appropriate.

''(3) ADJUSTMENTS.—

''(A) IN GENERAL.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (2), the Secretary shall increase or decrease the amount of the individual's monthly premium under this part (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this part during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (2) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B) INTEREST.—

''(i) INCREASE.—In the case of an individual for whom the amount initially determined by the Secretary under paragraph (2) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (2), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by an amount of interest equal to the sum of the amounts determined under clause (ii) for each of the months described in such clause.

''(ii) COMPUTATION.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (2) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (2) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

''(iii) EXCEPTION.—Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (2) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

''(C) STEPS TO RECOVER AMOUNTS DUE FROM PREVIOUSLY ENROLLED BENEFICIARIES.—In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this part for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium under this part for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(D) DECEASED BENEFICIARY.—In the case of a deceased individual for whom the amount of the monthly premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(4) WAIVER BY SECRETARY.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

''(5) TRANSFER TO PART B TRUST FUND.—

''(A) IN GENERAL.—The Secretary shall transfer amounts received pursuant to this subsection to the Federal Supplementary Medical Insurance Trust Fund.

''(B) DISREGARD.—In applying section 1844(a), amounts attributable to subparagraph (A) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B) thereof.''

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting ''or section subsection (h)'' after ''subsections (b) and (e)'';

(B) in subsection (a)(3) of section 1839(a), by inserting ''or subsection (h)'' after ''subsection (e)'';

(C) in subsection (b), inserting ''(and as increased under subsection (h))'' after ''subsection (a) or (e)''; and

(D) in subsection (f), by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting ''or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted,'' before ''he may''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(19) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Centers for Medicare & Medicaid Services return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3)(A) of section 6103(p) of such Code is amended by striking ''or (18)'' each place it appears and inserting ''(18), or (19)''.

(B) Paragraph (4) of section 6103(p) of such Code is amended by striking ''or (16)'' and inserting ''(16), or (19)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 2006.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(19) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 2002.

Mrs. FEINSTEIN. Mr. President, this amendment is presented on behalf of myself, Senators NICKLES, CHAFEE, LINDSEY GRAHAM, ALEXANDER, and MCCAIN.

This amendment provides that Medicare beneficiaries with an annual adjusted gross income of over $200,000, or above, pay the full cost of the Medicare Part B premium. The amendment uses a sliding scale to ramp up the beneficiary's share of the Part B premium.

The amendment we are offering would hold Medicare beneficiaries with annual adjusted gross incomes between $100,000 and $150,000 a year responsible for 50 percent of the cost of the premium. In 2003, this amounts to $116.40 a month, or $1,396 annually, rather than $58.20 monthly, or $698 annually, which is what the beneficiary pays today for the benefit.

Medicare beneficiaries with incomes between $150,000 a year and $200,000 a year—that is $300,000 to $400,000 for a couple—would be responsible for 75 percent of the total cost of the Part B premium. In 2003, this amounts to $174 or $2,095 annually.

Medicare beneficiaries with annual incomes above $200,000—that is $400,000 for couples—would be responsible for 100 percent of the total cost of the premium. In 2003, this amounts to $232.80 a month, or $2,793 annually. Now, for a beneficiary with an annual income of $200,000, this amounts to less than 1.4 percent of their annual income. For the vast majority of Medicare beneficiaries, some 37 million of the 38 million beneficiaries, Part B premiums would remain the same as they are today.

According to the Census Bureau, about 98 percent of all Medicare beneficiaries have annual incomes below $100,000. So the amendment we are proposing will affect about 2 percent of the most affluent and well off Medicare beneficiaries.

Let me be clear. This amendment does not deprive any Medicare beneficiary of any benefit. What this amendment says is that if you can afford to pay the price for the Medicare Part B premium, you should. Those Medicare beneficiaries who have annual incomes below $100,000 a year will still be able to receive a 75-percent Government subsidy for their premium.

Now, I strongly believe the time has come to begin to income-relate some of these benefits. The Federal Government should not be subsidizing the Part B premiums of those beneficiaries who can afford to pay for the cost of the premiums themselves.

Much has changed since the creation of Medicare in 1965. People are living longer, due in large part to improved diagnostic tools and treatment. There is no way Congress could have predicted the number of people who would come to rely on Medicare or the rate at which medical expenses would grow. When Medicare was established in 1965, the Part B premium was set at a level to cover about 50 percent of program costs. With medical inflation, the dollar amount of the premium has declined to cover only 25 percent of program costs.

The Omnibus Budget Reconciliation Act of 1993 established the Medicare Part B premium to equal 25 percent of the program cost from 1996 to 1998. The Balanced Budget Act of 1997 permanently established the Part B premium at 25 percent. The bill to balance the budget in 1997 that passed out of the Senate Finance Committee included a provision to income relate the Medicare Part B premium. So this is nothing new.

The provision included in 1997 would have had beneficiaries with incomes over $50,000 for an individual and $75,000 for a couple paying a greater share of the premium. This provision was stripped out during conference.

Well, we were in a different financial situation when Congress made the decision to set the beneficiary's share of the Part B premium at 25 percent in 1997. At that time, we had only a $22 billion deficit. The next year the budget was in surplus to the tune of $69 billion.

With a Federal budget deficit of over $400 billion in the year 2003 and an increase in the Federal debt of $5.3 trillion, for a total of $12 trillion in debt expected by 2013, I believe that now is the time to rethink the premium structure of Medicare Part B.

As the baby boomers age, there will be an increasing reliance on and demand for the Medicare Program.

The number of people age 65 and older will more than double over the coming decades, rising from 37 million today to 70 million in 2030 and 82 million in 2050. Over the next 75 years, the Medicare program will cost 71 percent more than that provided under current law in order to meet its needs.

It is predicted the Medicare hospital trust fund will be insolvent by 2030. The CBO projects Medicare spending will nearly quadruple by 2075 in order to meet the growing need for the program, with budget outlays of $277 billion in 2003. This means spending for the program could reach $1.1 trillion by 2075.

With the legislation currently before the Senate, Congress is proposing some major changes to the Medicare Program. I am in full support of adding a drug benefit, but Congress should also rethink the financing mechanisms of the program, and this bill is short in that direction. High-income beneficiaries can afford to pay a larger share of Medicare's costs, at least of

the premium. They can afford to pay for the benefits they receive.

In light of the fact the Federal Government has just provided tax cuts in the range of $1,841 for people with incomes between $77,000 and $154,000 and up to $30,000 for people with incomes above $374,000, it seems to me people with annual incomes above $200,000 can afford to pay $2,793, which is the annual premium for Medicare Part B this year.

We should focus funding so that 98 percent of Medicare beneficiaries who have an annual adjusted gross income of less than $100,000 can continue to access benefits. I think it is reasonable to ask those who can afford it to pay a greater share of the premium. We are still waiting for an official cost savings score from CBO, but I believe this amendment could save billions of dollars.

Once again, Mr. President, this amendment affects less than 2 percent and only those with incomes of more than $200,000 a year adjusted gross income would pay the full premium of about $2,900 a year. We think this is a reasonable proposal. It is scaled up. It impacts no one below $100,000 adjusted gross income a year, and at the maximum for people of over $200,000 a year in adjusted gross income, the premium would be just $2,900.

The income limits would be indexed to medical inflation and, according to current population survey data from 2002, only 2 percent, or about 1 million people of the 38 million Medicare beneficiaries, have incomes of over $100,000 a year. This would protect the tax subsidy for people who need it by encouraging those who have the dollars simply to pay either a greater share of the premium cost or the full premium cost.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I join with Senator FEINSTEIN, Senator NICKLES, and others in presenting this amendment this evening. I believe this income-related Part B premium for only the wealthiest of seniors, a little over 1 percent of the entire Medicare population, is necessary to sustain the long-term solvency of the Medicare Program.

I wish to make just three points on this issue. First, as Senator FEINSTEIN has said, previous Congresses have worked on this issue. In 1997, the Senate voted 70 to 30 to do exactly what we are doing here, and most of those Senators are still here today.

Second, many of these seniors can afford this added premium. Most seniors, it is safe to say, who are making over $100,000 a year have already paid off their mortgages. They have paid off their loans. They have educated their children. They can afford these higher premiums which would go from only $1,400 a year to $2,800 a year, at the most, depending on the income they make. So seniors who are making $100,000 at the most will pay only $1,400 a year, and those making $200,000 will pay $2,800 a year. I do not think that is too much to ask to help keep this program solvent.

Finally, if we do not do this today, some other Congress is going to do it. In 1997, the National Bipartisan Commission on the Future of Medicare was created to resolve the long-term insolvency facing the system. That was in 1997 and it was known as the Breaux-Frist Commission. They did not report their work to Congress. They fell short of the votes necessary to report their work to Congress.

However, it is interesting to note that one of the reasons they failed to get the votes to report to Congress was the President at the time, President Clinton, called for putting aside 15 percent of budget surpluses the next 15 years to pay down the debt and to shore up Medicare. Fifteen years of budget surpluses—when will we see those again?—to shore up Medicare. Because the Breaux-Frist plan did not include that, they did not get the votes necessary.

Mr. President, now is the time to adopt this amendment. If we do not adopt it, future Congresses will have to wrestle with this dilemma.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, for the information of our colleagues, I am going to make a couple comments on this amendment. There may be an amendment by the Senator from Pennsylvania that will require a vote on or in relation to Senator CORZINE's amendment. I think we are close to finishing. I hope we can. I just make those comments.

I compliment Senator FEINSTEIN and also Senator CHAFEE, Senator ALEXANDER, Senator MCCAIN, and others for supporting this amendment. Senator CHAFEE mentioned we passed the income-related Part B premium several years ago with 70 votes. I believe the majority of people, a strong majority—looking at the people who voted for it—are still here. I hope we vote for it again.

Medicare has some big problems long term. The bill before us has a lot of new subsidies but does not have a lot of reform to make it affordable for future generations.

Part B right now is subsidized by general revenues 3 to 1 Federal Government and individuals. The amendment before us on Part B says if individuals have income above $100,000, they should pay at least 50 percent. If they have income above $200,000, they should pay it all. For couples, that would be $400,000. A couple could make $400,000 before they pay all their Part B premium.

Surely we can do that. Why should we ask our kids and/or our grandkids, who might have incomes of $20,000 or $30,000, to be subsidizing individuals to that degree?

I compliment my colleagues for this amendment. I will read from the annual report of the board of trustees of the HI trust fund. It says:

> Similarly, SMI general revenues in the year 2002 were equivalent to about 7.8 percent of personal and corporate Federal income tax collected in that year. If such tax is to remain at the current level relative to the national economy, then SMI—

That is Part B—

> general revenue financing in 2077 would represent roughly 32 percent of total income taxes.

That is almost one-third of total income taxes. That is not affordable. That is not sustainable. So I think the amendment we have before us by Senator FEINSTEIN and Senator CHAFEE and others is a small step in the right direction to try to make this system more affordable for future generations.

I compliment my colleagues for this amendment. I urge our colleagues to support this small step toward reform.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

IN REMEMBRANCE OF STROM THURMOND

Mr. FRIST. Mr. President, a few moments ago we were made aware that at 9:45 tonight a close friend, a confidant, a colleague to most of us in this body, Strom Thurmond, passed away.

It was a century ago when Mark Twain was alive and Teddy Roosevelt was President that James Strom Thurmond was born in South Carolina and at that time began a life unmatched in public service. Just about all of us in this body have had the real privilege of serving alongside Strom Thurmond. A long-time friend of Senator Thurmond, Hortense Woodson, once said of him:

> Everything he's done has been done in the full. There's no halfway doings about Strom.

Indeed, Strom Thurmond will forever be a symbol of what one person can accomplish when they live life, as we all know he did, to the fullest. To his family and his friends, we offer our sincerest sympathies.

It was unexpected that he would die this evening while we are in the middle of completing a very historic bill, and it would be clearly appropriate for us to make recognition of his passing for a moment now, with plans, either after completion of the bill tonight or tomorrow, for people to make more extended statements.

Again, we extend to his family our deepest sympathies and our continued prayers.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I join with the majority leader in expressing

our heartfelt condolences to the family and to the State of Strom Thurmond. In many respects, he was a legend. Many of us had the good fortune to serve with him as a Senator. He was a Governor, a Presidential candidate, a soldier, a father, a citizen. In many respects, he fought, lived, contributed, and legislated in a way that will be written about and commented on for years and decades to come.

Much more will be said, but I think as we consider his contribution tonight we can say, as we consider the opportunity that we had to serve with him, Republicans and Democrats, that it was our privilege to do so.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. HOLLINGS. Mr. President, my friend and colleague of 36 years in the Senate is gone. A giant oak in the forest of public service has fallen.

I started with Senator Thurmond as a young law student in 1946 when he first ran for Governor and have been more or less with him over these many, many years. I will have a real recount of our work together later. That is the way it was even though we ended up on other sides of the aisle. There was never any doubt about the interests of South Carolina.

We have all this argument going on now with respect, for example, to judges. He and I got together very early. We agreed when his President was in office from his particular party that he had the appointment, but he always asked me about it and, of course, I in turn asked him about it. We checked with each other. That is the kind of way we worked together over the some 36 years.

I can say just a living legend of South Carolina now has been terminated. But I want to give Nancy and the children my heartfelt condolences. Peatsy and I have known them and been with them over the many, many years. I will have more to say at a later time. I thank the leadership for their recognition. I hope, perhaps, when we complete our work tonight, we might adjourn out of respect for our colleague.

Mr. FRIST. Why don't we take just a moment of silence in honor of Strom Thurmond.

(Moment of Silence.)

Mr. FRIST. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENT NO. 1132

Mr. SANTORUM. Mr. President, I call up amendment No. 1132 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Pennsylvania [Mr. SANTORUM] proposes an amendment numbered 1132.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow eligible beneficiaries in MedicareAdvantage plans to elect zero premium, stop-loss drug coverage protection)

On page 343, between lines 15 and 16, insert the following:

''(f) ZERO PREMIUM STOP-LOSS PROTECTION AND ACCESS TO NEGOTIATED PRICES FOR ELIGIBLE BENEFICIARIES ENROLLED IN MEDICAREADVANTAGE PLANS.—

''(1) IN GENERAL.—Notwithstanding any provision of this part or part D, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage otherwise required, the plan makes available such coverage with the following modifications:

''(A) NO PREMIUM.—Notwithstanding subsection (d) or sections 1860D–13(e)(2) and 1860D–17, the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage shall be zero.

''(B) BENEFICIARY RECEIVES ACCESS TO NEGOTIATED PRICES AND STOP-LOSS PROTECTION FOR NO ADDITIONAL PREMIUM.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

''(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

''(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4), except that in applying such subsection, '$5000.00' shall be substituted for '$3,700' in subparagraph (B)(i)(I) of such subsection.

''(iii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

''(C) APPLICATION OF LOW-INCOME SUBSIDIES.—Notwithstanding subsection (f) or section 1860D–19, the Administrator shall not apply the following provisions of subsection (a) of such section:

''(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

''(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

''(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

''(2) PENALTY FOR ENROLLING IN A ZERO PREMIUM STOP-LOSS PROTECTION PLANS AFTER INITIAL ELIGIBILITY FOR SUCH ENROLLMENT.—In the case of an eligible beneficiary that enrolled in a plan offered pursuant to this subsection at any time after the initial enrollment period described in section 1860D–2, the Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under such a plan but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under this paragraph in a manner that is similar to the manner such provisions apply to the penalty under part D.

''(3) PROCEDURES.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this subsection.

''(4) NO EFFECT ON MEDICARE DRUG PLANS.—This subsection shall have no effect on eligible beneficiaries enrolled under part D in a Medicare Prescription Drug plan or under a contract under section 1860D–13(e).''

Mr. SANTORUM. Mr. President, one of the key components that many Members on this side of the aisle would like to see accomplished is to draw as many people as possible into the competitive model set up in this bill. We believe it is the more efficient, higher quality delivery of health care services, the Medicare Advantage plan.

Unfortunately, through negotiations, a lot of the incentives the President has to encourage people to get into those plans and thereby make them work have been taken out in the current version on the floor. That is to the great consternation, I know, of the White House and many Members on this side of the aisle.

For quite some time I have been trying to think how they can create incentives—carrots, if you will, as opposed to sticks—to encourage people to get into these kinds of plans. Originally, I intended to offer a differential benefit—in other words, a benefit that would have what I call a standard benefit in the fee-for-service option and an enhanced benefit in the Medicare Advantage option. I was fairly convinced, in discussing with the people on my side of the aisle, we probably would not have a chance to succeed; that there were people who had made commitments that a differential benefit was not something for this time.

I went about trying to figure out, could we create incentives to people to come into Medicare Advantage, which I believe is the future of Medicare and the best way to run the system without creating a differential benefit. The amendment before the Senate does that. The amendment before the Senate creates an option for beneficiaries who participate in Medicare Advantage. It is a pharmaceutical option. Instead of just having no pharmaceutical benefit, which you could if you do not get into the Medicare Advantage Program, we have the standard benefit which is required if you participate in the PPOs, HMOs, and POSs that will be created here.

What I will do with this amendment is create another option for seniors who select Medicare Advantage. That option would be a zero premium catastrophic benefit. So you could choose between the standard benefit, the $35 premium, and the 50 percent copay, and the donut hole, and all the things described over and over again, or if you did not want to pay a premium but wanted some catastrophic coverage,

wanted some benefit, no premium, no cost, you could join this.

The CBO scored this as attracting twice as many people into the PPOs and HMOs as the underlying bill. It would make those plans much more desirable for beneficiaries. I believe that should be one of the goals of this legislation, to make the new and improved and stronger plan a more robust plan.

Unfortunately, according to the Congressional Budget Office, when people move from the fee-for-service plan into the Medicare Advantage plan, the Congressional Budget Office assumes those plans will be more expensive. And because they will be more expensive, this amendment costs money. It doubles the participation but costs $20, to $25 billion, which is the back of the envelope. And God bless the CBO; that is the best they could do at this late hour.

I firmly believe this is a reasonable compromise between those who would not want to have the differential benefit and those who would because it is unfair to the fee-for-service participants and those who believe we need to have an incentive for people to get into the Medicare Advantage Program. This strikes the compromise. This is where we could go.

There are all sorts of things we have done to eliminate adverse selection and all the other problems inherent in offering two different benefits. We believe we actually address the vast majority of those problems in this amendment. Nevertheless, we have run into the roadblock that this bill has run into the entire time when it comes to the competitive model and CBO and their estimation of costs.

For the record, the White House does not see it that way. The White House sees the competitive model as saving money. Under their scoring, this would probably actually save money and move people into a higher quality, more efficient system.

AMENDMENT NO. 1132 WITHDRAWN

As a result of the fact of the score which is $20 to $25 billion, and we do not have that, I am going to withdraw my amendment and hope this idea which I believe is in the center here is a compromise between two competing ideas of how to structure this bill.

It will be considered in conference as a way of trying to bring the two sides together in something that does not disadvantage the fee-for-service plan but creates an opportunity for incentives to go to the Medicare Advantage plan.

Mr. President, with that I ask unanimous consent to withdraw my amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

The Senator from Oklahoma.

Mr. NICKLES. I compliment my colleague from Pennsylvania. Especially this late at night, when a lot of us are thinking about our departed friend and colleague, Senator Thurmond, I appreciate his withdrawing this amendment.

For the information of our colleagues, I think we are very close to finishing this bill. We may have one or two rollcall votes. I think we are just about ready to vote on the Feinstein-Chafee amendment and possibly one other amendment, and I think we are very close to be able to vote on final passage, for the information of our colleagues.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1060

Mr. KENNEDY. Mr. President, I will just take a moment to address the amendment of the Senator from California, Mrs. FEINSTEIN, and her colleagues, in terms of means testing the Medicare system. That is what we would be doing, changing what is effectively an insurance system into a welfare system. There is, really, no question about that.

The fact is, the Part B of the Medicare system is basically a progressive system as it is at the present time. Wealthy people are paying a great deal more into that system than they are taking out.

My concern is, if this passes, it is only a question of time before the healthiest individuals who can qualify under the Part B premium are going to leave the Medicare system and it is going to deteriorate into a general welfare system. The kind of Medicare system seniors relied on, day in and day out, would be destroyed. Make no mistake about it.

That is why the AARP is strongly opposed to it, as well as the National Committee to Preserve Social Security.

I hope this amendment is not accepted. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

AMENDMENT NO. 990, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that amendment No. 990, previously adopted, be modified with language I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

At the end of subtitle A of title II, add the following:

SEC. ___. IMPROVEMENTS IN MEDICARE-ADVANTAGE BENCHMARK DETERMINATIONS.

(c) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICAREADVANTAGE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(B) by adding at the end the following new subparagraph:

''(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

AMENDMENT NO. 960, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that Senator DAYTON's amendment, No. 960, be modified with the modification that I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require a streamlining of the medicare regulations)

At the end of subtitle A of title V, add the following:

SEC. ___. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'') to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (b)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its infeasibility. He shall then establish a possible reduction to be achieved by January 1, 2005.

VITIATION OF VOTE ON AMENDMENT NO. 1041

Mr. GRASSLEY. Mr. President, I ask unanimous consent to vitiate the vote by which amendment No. 1040 was adopted.

Mr. BAUCUS. Amendment No. 1041.

Mr. GRASSLEY. I am sorry, No. 1041.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1096

Mr. GRASSLEY. I ask unanimous consent that the pending amendment be temporarily set aside, amendment No. 1096 be called up, adopted, and the motion to reconsider be laid on the table.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment (No. 1096) was agreed to, as follows:

(Purpose: To require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project)

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms ''hospital'' and ''critical access hospital'' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

AMENDMENT NO. 989, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Collins amendment, amendment No. 989, be modified with modifications that I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To increase medicare payments for home health services furnished in a rural area)

At the appropriate place in subtitle C of title IV, insert the following:

SEC. ___. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

''(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

''(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

''(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).''.

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following: ''Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

AMENDMENTS NOS. 1122, 1074, 1023, 1114, 1115, 1045, 1058, 1117, 1044, 1056, 996, 1013, 1121, 989, AS MODIFIED, 1126, 996, 1118, 1085, 1017, 968, 948, 960 AS MODIFIED, 1054, AND 1030

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside and that the following amendments be called up en bloc: No. 1122, Brownback; No. 1074, Coleman; No. 1023, Collins; No. 1114, Kyl; No. 1115, Kyl; No. 1045, Chambliss; No. 1058, Craig; No. 1117, Baucus; No. 1044, Bayh; No. 1056, Shelby; No. 996, Reed of Rhode Island; Bond amendment No. 1013; Kyl, No. 1128; Collins, No. 989, as modified; Dole, No. 1126, with Edwards added as a cosponsor; Reed of Rhode Island, No. 996; Specter, No. 1118; Specter, No. 1085.

The PRESIDENT pro tempore. Is there objection?

Mr. BAUCUS. Mr. President, this side agrees.

The PRESIDENT pro tempore. Is there objection?

If not, the amendments will be considered en bloc.

The amendments are as follows:

(Amendments Nos. 1122 and 1117 are printed in today's RECORD under ''Text of Amendments.'')

(Amendments Nos. 1017, 968, 948, 1054 and 1030 are printed in a previous edition of the RECORD.)

AMENDMENT NO. 1074

(Purpose: To amend title XVIII of the Social Security Act to make improvements in the national coverage determination process to respond to changes in technology)

At the end of subtitle C of title IV, add the following:

SEC. ___. IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting ''consistent with subsection (j)'' after ''the Secretary shall ensure''; and

(B) by adding at the end the following new subsection:

''(j) NATIONAL COVERAGE DETERMINATION PROCESS.—

''(1) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

''(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

''(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

''(2) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

''(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

''(B) provide a 30-day period for public comment on such draft;

''(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

''(D) include in such final decision summaries of the public comments received and responses thereto;

''(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

''(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C).

''(3) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term 'national coverage determination' has the meaning given such term in section 1869(f)(1)(B).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

AMENDMENT NO. 1023

(Purpose: To provide for the establishment of a demonstration project to clarify the definition of homebound)

At the appropriate place in subtitle B of title IV, insert the following:

SEC. ___. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term ''activities of daily living'' means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

AMENDMENT NO. 1114

(Purpose: To require the GAO to study the impact of price controls on pharmaceuticals)

At the appropriate place, insert the following:

SEC. . GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G–7 COUNTRIES.

(A) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance;

(2) The proportion of the costs for innovation borne by American consumers, compared with consumers in the other six countries;

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production (''Ramsey prices'');

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health;

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States;

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied;

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant; and

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violation of intellectual property rights for prescription medicines.

(B) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (A).

AMENDMENT NO. 1115

(Purpose: To express the sense of the Senate concerning Medicare payments to physicians and other health professionals)

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without Congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991–2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by Medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

AMENDMENT NO. 1045

(Purpose: To provide for a demonstration project for the exclusion of brachytherapy devices from the prospective payment system for outpatient hospital services)

At the end of subtitle B of title IV, add the following:

SEC. ___. DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), the amount of payment for a device of brachytherapy furnished under the demonstration project shall be equal to the hospital's charges for each device furnished, adjusted to cost.

(b) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—The Secretary shall create additional groups of covered

OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium–103 and iodine–125 devices.

(c) DURATION.—The Secretary shall conduct the demonstration project under this section for the 3-year period beginning on the date that is 90 days after the date of enactment of this Act.

(d) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project conducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration project under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration project under this section was not implemented.

AMENDMENT NO. 1058

(Purpose: To restore the Federal Hospital Insurance Trust Fund to the financial position it would have been in if a clerical bookkeeping error had not occurred)

At the appropriate place in title VI, insert the following:

SEC. ___. RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DEFINITIONS.—In this section:

(1) CLERICAL ERROR.—The term ''clerical error'' means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) TRUST FUND.—The term ''Trust Fund'' means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) CORRECTION OF TRUST FUND HOLDINGS.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) APPROPRIATION.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

AMENDMENT NO. 1044

(Purpose: To adjust the urban health provider payment)

At the appropriate place, insert the following:

SEC. ___. URBAN HEALTH PROVIDER ADJUSTMENT.

(a) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in subsection (b) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

(b) HOSPITAL DESCRIBED.—A hospital is described in this subsection if the hospital—

(1) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(2) is located in Marion County, Indiana.

(c) LIMITATION.—The payment adjustment described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(1)(A)).

AMENDMENT NO. 1056

(Purpose: To prevent the Secretary of Health and Human Services from modifying the treatment of certain long-term care hospitals as subsection (d) hospitals)

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—The last sentence of section 1886(d)(1)(B) is amended by inserting '', and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)'' before the period at the end.

(b) TREATMENT OF PROPOSED REVISION.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) EFFECTIVE DATE.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

AMENDMENT NO. 1013

(Purpose: To ensure that patients are receiving safe and accurate dosages of compounded drugs)

At the appropriate place, insert the following:

SEC. ___. COMMITTEE ON DRUG COMPOUNDING.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an Committee on Drug Compounding (referred to in this section as the ''Committee'') within the Food and Drug Administration on drug compounding to ensure that patients are receiving necessary, safe and accurate dosages of compounded drugs.

(b) MEMBERSHIP.—The membership of the Advisory Committee shall be appointed by the Secretary of Health and Human Services and shall include representatives of—

(1) the National Association of Boards of Pharmacy;

(2) pharmacy groups;

(3) physician groups;

(4) consumer and patient advocate groups;

(5) the United States Pharmacopoeia; and

(6) other individuals determined appropriate by the Secretary.

(c) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Committee shall submit to the Secretary a report concerning the recommendations of the Committee to improve and protect patient safety.

(d) TERMINATION.—The Committee shall terminate on the date that is 1 year after the date of enactment of this Act.

AMENDMENT NO. 1121

(Purpose: To express the sense of the Senate concerning the structure of Medicare reform and the prescription drug benefit to ensure Medicare's long-term solvency and high quality of care)

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) FINDINGS.—The Senate makes the following findings:

(1) America's seniors deserve a fiscally-strong Medicare system that fulfills its promise to them and future retirees.

(2) The impending retirement of the ''baby boom'' generation will dramatically increase the costs of providing Medicare benefits. Medicare costs will double relative to the size of the economy from 2 percent of GDP today to 4 percent in 2025 and double again to 8 percent of GDP in 2075. This growth will accelerate substantially when Congress adds a necessary prescription drug benefit.

(3) Medicare's current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease management programs, and host of other advances. Reforming Medicare to create a more self-adjusting, innovative structure is essential to improve Medicare's efficiency and the quality of the medical care it provides.

(4) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of America's seniors, not the government, and would create a powerful incentive for private-sector Medicare plans to provide the best quality health care to seniors at the most affordable price.

(5) The method by which the national preferred provider organizations in the Federal Employees Health Benefits Program have been reimbursed has proven to be a reliable and successful mechanism for providing Members of Congress and federal employees with excellent health care choices.

(6) Unlike the Medicare payment system, which has had to be changed by Congress every few years, the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most.

(2) Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2006 to ensure the long and short term viability of such options for America's seniors.

(3) Develop a payment system for the Medicare Advantage preferred provider organizations similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program.

(4) Limit the addition of new unfunded obligations in the Medicare program so that the long-term solvency of this important program is not further jeopardized.

(5) Incorporate private sector, market-based elements, that do not rely on the inefficient Medicare price control structure.

(6) Keep the cost of structural changes and new benefits within the $400 billion provided for under the current Congressional Budget Resolution for implementing Medicare reform and providing a prescription drug benefit.

(7) Preserve the current employer-sponsored retiree health plans and not design a benefit which has the unintended consequences of supplanting private coverage.

(8) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(9) Restore the right of Medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the government contribution.

AMENDMENT NO. 989, AS MODIFIED

(Purpose: To increase medicare payments for home health services furnished in a rural area)

At the appropriate place in subtitle C of title IV, insert the following:

SEC. ___. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

''(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

''(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

''(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).''.

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S. C. 1395fff(b)(5)) is amended by adding at the end the following:''Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

AMENDMENT NO. 1126

(Purpose: To provide for the treatment of certain entities for purposes of payments under the medicare program)

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) BUDGET NEUTRAL WITHIN NORTH CAROLINA.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such payments that would have been made in the year if this subsection had not been enacted.

(b) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act, Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) APPLICATION AND BUDGET NEUTRAL WITHIN NORTH CAROLINA.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be implemented in a budget neutral manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the total amount of expenditures that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(c) CONSTRUCTION.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

AMENDMENT NO. 996

(Purpose: To modify the GAO study of geographic differences in payments for physicians' services relating to the work geographic practice cost index)

In section 445(a) of the bill, strike paragraph (6) and insert the following:

''(6) an evaluation of the appropriateness of extending such adjustment or making such adjustment permanent;

''(7) an evaluation of the adjustment of the work geographic practice cost index required under section 1848(e)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(A)(iii)) to reflect ¼ of the area cost difference in physician work;

''(8) an evaluation of the effect of the adjustment described in paragraph (7) on physician location and retention in higher than average cost-of-living areas, taking into account difference in recruitment costs and retention rates for physicians, including specialists; and

''(9) an evaluation of the appropriateness of the ¼ adjustment for the work geographic practice cost index.''.

AMENDMENT NO. 1118

(Purpose: To express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

AMENDMENT NO. 1085

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating ''tolerance'' corridors for variations around the update target trend.

AMENDMENT NO. 960

(Purpose: To Require a Streamlining of the Medicare Regulations)

At the end of subtitle A of title V, add the following:

SEC. ___. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'') to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers. If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (B)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its unfeasibility. He shall then establish a feasible reduction to be received by January 1, 2005.

Mr. GRASSLEY. I ask unanimous consent that these amendments and the following pending amendments be adopted en bloc and that the motion to reconsider be laid upon the table: Amendment No. 1017, Allard; No. 968, Harkin; No. 948, Graham of South Carolina; No. 960, Dayton; No. 1054, Feingold; No. 1030, Enzi.

The PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

The amendments were agreed to.

Mr. GRASSLEY. Thank you. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRAHAM of South Carolina. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

STROM THURMOND

Mr. GRAHAM of South Carolina. Mr. President, I rise to make a brief statement, like my colleague from South Carolina, Senator HOLLINGS, about the passing of Senator Thurmond. This is something I really don't know how to put in words. All of us from South Carolina knew Senator Thurmond in so many ways. But his colleagues in this body, the vast majority of you, have served with him for many years. You have great admiration and fondness for Senator Thurmond but I stand before you as his successor. I often state back home that we change Senators every 50 years and that so many people have been waiting to take Senator Thurmond's place. The jokes just go on and on about what a rich life he has lived.

Tonight his family is mourning his passing. Whether a person lives to be 100 or 200, it is difficult to lose your father. If you lose someone you love, it is always difficult. But when you think about Senator Thurmond, you always have a smile on your face.

He lived a rich life. He lived at times a controversial life. But the biggest testament I can give to Senator Thurmond is that he changed. He changed with the times.

Those of you who embraced him during difficult times your love was much appreciated. Recently people have tried to freeze Senator Thurmond in time which is unfair to him or anyone else. Those who knew him best understood that he changed with the times. And his legacy in my State across party lines, across racial lines, and across regional lines was that he was the go-to guy. If you had a problem with your family or with your business, the first thought in your mind, if the Government was involved, or if somebody was treating you unfairly, was get on the phone and call Senator Thurmond. You would get a phone call back, and he would go to bat for you. Whether you owned the company, or you were the janitor, whether you were black, white, rich or poor, his office and he as a person had a reputation of going to bat for individuals. To me, that is his greatest legacy.

I stand before you as his successor—but not only that, as his friend. He embraced my campaign in 1995. He came to campaign for me when he was 93 years of age. And I was worried to death about if he could make it through the day. Three days later I was glad to see him leave because he about killed me.

He had enthusiasm and passion like no one I have ever met in my life. He did things he didn't have to do. He was a sitting judge in South Carolina in his 40s. He left the judgeship to go volunteer for the Army. He landed in a glider on D-Day, he was shot up, the pilot was killed, and he fought the Germans until they quit, and then he went over to Japan and fought until they quit.

This man, your friend, my friend, South Carolina's favorite son, is gone but he will never be forgotten. His biggest legacy is in the small things he did—not the large things he did. There are so many large things he accomplished. But he lives on in families.

Great relationships were established, and good constituent service. He won his last election by getting more African-American votes than any Republican in the South.

All I can say about Senator Thurmond is that we pray for his family, we mourn his loss, but we thank God that He provided us a great public servant.

Well done, Senator Thurmond.

Thank you, Mr. President.

Mr. NICKLES. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nomination on today's executive calendar:

Calendar No. 252, the nomination of Joshua Bolten to be Director of the Office of Management and Budget. I further ask unanimous consent that the nomination be confirmed, the motion to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

The nomination was considered and confirmed.

LEGISLATIVE SESSION

The PRESIDENT pro tempore. Under the previous order, the Senate will return to legislative session.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

Mr. BAUCUS. Mr. President, will the Chair state the regular order?

The PRESIDENT pro tempore. The pending amendment numbered 1060, as modified is the regular order.

Mr. BAUCUS. Mr. President, is that the Nickles-Feinstein amendment?

The PRESIDENT pro tempore. It is.

Mr. BAUCUS. Mr. President, I move to table the Nickles-Feinstein amendment, and I ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 38, nays 59, as follows:

[Rollcall Vote No. 261 Leg.]

YEAS—38

Akaka	Edwards	Murray
Baucus	Grassley	Nelson (FL)
Bayh	Harkin	Nelson (NE)
Bingaman	Hollings	Pryor
Boxer	Inouye	Reed
Breaux	Johnson	Reid
Byrd	Kennedy	Rockefeller
Cantwell	Lautenberg	Sarbanes
Clinton	Leahy	Schumer
Corzine	Levin	Snowe
Daschle	Lincoln	Specter
Dorgan	Mikulski	Stabenow
Durbin	Miller	

NAYS—59

Alexander	Dayton	Landrieu
Allard	DeWine	Lott
Allen	Dodd	Lugar
Bennett	Dole	McCain
Biden	Domenici	McConnell
Bond	Ensign	Murkowski
Brownback	Enzi	Nickles
Bunning	Feingold	Roberts
Burns	Feinstein	Santorum
Campbell	Fitzgerald	Sessions
Carper	Frist	Shelby
Chafee	Graham (FL)	Smith
Chambliss	Graham (SC)	Stevens
Cochran	Gregg	Sununu
Coleman	Hagel	Talent
Collins	Hatch	Thomas
Conrad	Hutchison	Voinovich
Cornyn	Jeffords	Warner
Craig	Kohl	Wyden
Crapo	Kyl	

NOT VOTING—3

Inhofe	Kerry	Lieberman

The motion was rejected.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, what is the business before the Senate?

The PRESIDENT pro tempore. Amendment No. 1060, as modified.

Mr. GRASSLEY. I urge adoption of the amendment.

The PRESIDENT pro tempore. Is there further debate?

Mr. BAUCUS. Mr. President, will the Chair identify the sponsors of that amendment?

The PRESIDENT pro tempore. Senator BAUCUS for Senator FEINSTEIN, amendment No. 1060, Part B premium, subtitle (d).

Mr. BAUCUS. Mr. President, the Senate is ready to vote.

The PRESIDENT pro tempore. The question is on agreeing to the amendment.

The amendment (No. 1060), as modified, was rejected.

Mr. BAUCUS. I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDENT pro tempore. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I have a unanimous consent request to correct a previous unanimous consent request. In a previous unanimous consent request, I referred to amendment No. 990 when I meant to refer to the previously adopted Murray amendment No. 961.

I ask unanimous consent to make that change.

I referred to the Kyl amendment No. 1128 when I meant to refer to Kyl amendment No. 1121.

I also ask unanimous consent to make that change.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

AMENDMENT NO. 1133

Mr. GRASSLEY. Mr. President, I send an amendment to the desk.

The PRESIDENT pro tempore. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY] proposes an amendment numbered 1133.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDENT pro tempore. Without objection, it is so ordered.

(The amendment, No. 1133, is printed in today's RECORD under ''Amendments Submitted.'')

Mr. GRASSLEY. Mr. President, is there no discussion necessary on the amendment?

The PRESIDENT pro tempore. Who seeks recognition?

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I would just like to say that we have help for our teaching hospitals in the managers' amendment. It is not much. But I am working with all of the managers, the ranking member as well as the chairman, to try to increase funding for teaching hospitals.

I want to point out our teaching hospitals must have the support that is in this bill at a higher percentage if we are going to keep the young physicians trained and if our country will keep the greatest health care system in the world.

I thank the managers for helping me put that in the managers' amendment.

The PRESIDENT pro tempore. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I oppose the managers' amendment because of an amendment that is in the managers' amendment, the Corzine amendment which provides three States the opportunity to basically opt out of the Medicare Program for prescription drugs and have an entitlement flow of funding going to the States for the States to develop their own stand-alone drug benefit. As a result of that, States like mine and two others will not have the advantage of an integrated drug benefit which I fought very strongly for on this floor and which I believe will also lead potentially to this unlimited entitlement flow of funds to the States because of the way this language is drafted, the potential for lots of mischief in respect to double dipping, inter-government transfers, disproportionate share payments. We could be opening a virtual Pandora's box. Yes. For my States and two others. But I think, frankly, it is not good policy and does not do the kind of improvement of the overall Medicare program which my State should participate in as well as the other States represented here.

There is no Federal oversight by the Secretary of Health and Human Services for this plan.

There are a host of other problems with this amendment. It is my understanding that the managers gave a commitment that this amendment be included in the package. And so to honor the chairman's commitment, I will not object to this amendment nor call for a vote to strike the amendment. But I, unfortunately, will have to vote against this bill.

The PRESIDENT pro tempore. Is there further debate?

Mr. GRASSLEY. I ask unanimous consent that the amendment be agreed to.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

The amendment (No. 1133) was agreed to.

AMENDMENTS EN BLOC WITHDRAWN

Mr. GRASSLEY. Mr. President, I ask unanimous consent to withdraw the pending amendments.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendments (Nos. 953, 958, 934, 964, 965, 980, 979, 973, 986, 990, 977, 993, 962, 1004, 1019, 1020, 1021, 999, 954, 1037, 1039, 1051, 1012, 1061, 1075, 1076, 1077, 1024, 1073, 1088, 1089, 1090, 1091, 1110, and 1041) were withdrawn.

ADULT DAY CARE

Mr. BUNNING. Mr. President, during consideration of this bill in the Finance Committee, I submitted language regarding adult day care which I and my staff were told by Finance Committee staff was acceptable and included in S. 1, the Prescription Drug and Medicare Improvement Act of 2003, as part of the base bill to be considered on the Senate floor. I was very thankful for your consideration and approval of my language, Chairman GRASSLEY.

Mr. GRASSLEY. Yes, Senator BUNNING, I remember your submitted language regarding Adult Day Care.

Mr. BUNNING. After we voted to pass S. 1 out of the Finance Committee, I have since learned that the adult day care language accepted and made part of the bill is not the language I submitted at all, but instead it is language based on a bill introduced by Senator SANTORUM related to the same issue.

Mr. GRASSLEY. Yes, this is true, and I apologize for the inaccurate information and misunderstanding provided to you and your staff from the Finance Committee on this issue. The language included in the base bill instead is based on Senator SANTORUM's bill.

Mr. BUNNING. While Senator SANTORUM's adult day care proposal and my adult day care language are different, they both share the same goal of providing services to those special and needy adults who require extra attention and care. However, I have some differences with Senator SANTORUM's proposal, and he has some differences with my proposed language.

Mr. SANTORUM. Yes, we do share the same goal on this adult day care issue, and we do have some fundamental differences with one another's proposals and language on the matter.

Mr. GRASSLEY. Yes, that is my understanding, as well.

Mr. BUNNING. I am hopeful that once this bill gets to conference, we and our staffs can work out our differences on this adult day care issue and find a solution that is amenable to all of us. It is also my understanding the current version of the House of Representative's prescription drug benefit bill includes the adult day care language which is identical to my language.

Mr. SANTORUM. I am willing to work on this matter further, and do agree that since the Senate's and House of Representative's versions on the adult day care language will be different, we will have to find a solution to our differences on this important issue.

Mr. GRASSLEY. I will be happy to work with both of you and our staffs to rectify this problem. Adult day care is an important issue, and being that the Senate and House of Representatives will have different language on this issue, it must be conferenced in a way to ensure that all with interests in this matter, including interested provider and senior organizations, are involved and approving of the final adult day care language. I am looking forward to further working with both of you on this matter.

Mr. BUNNING. Thank you, Mr. Chairman and Senator SANTORUM. I appreciate both your willingness to revisit this matter and your leadership on this important legislation for our seniors.

FEE FOR SERVICE

Mr. FRIST. Mr. President, I believe in assuring the ability of seniors who choose to do so to add their own funds on top of the government contribution in order to participate in private fee-for-service plans under Medicare. I also believe that private fee-for-service plans should be able to provide an unmanaged form of the subsidized prescription drug benefit.

Accordingly, I am committed to ensuring that the bill reported from the conference committee that will consider S. 1 and H.R. 1 incorporates the functional equivalent of those provisions in H.R. 1 that permit private fee-for-service plans to provide the subsidized prescription drug benefit as an unmanaged benefit whose premium amount, just like the premium amount such plans charge for the core Medicare benefit under current law, is not subject to governmental review or approval.

Mr. GRASSLEY. I agree.

REPEAL OF THERAPY CAPS

Mr. ENSIGN. Mr. President, I will withdraw my amendment to repeal the arbitrary beneficiary caps on therapy. However, I would urge my colleague from Iowa, the Chairman of the Finance Committee, to work in conference to find a way to delay this law. As you know, the beneficiary caps will have one of three results—beneficiaries will either: (1) pay 100 percent out-of-their own pocket once the caps are exceeded; (2) self-ration therapy care; or (3) forgo medically necessary care altogether. Mr. President, I recognize that the Chairman has been a voice to eliminate these caps and hope that a final Medicare bill further delays implementation of them.

Mrs. LINCOLN. Mr. President, I would like the opportunity to join my colleague from Nevada to speak in support of repealing the caps on outpatient physical therapy, occupational therapy, and speech-language pathology.

The current therapy cap discriminates against the most vulnerable of Medicare beneficiaries. While the majority of enrollees will not exceed an annual $1,590 limitation on rehabilitation services, approximately 13 percent of seniors and individuals with disabilities covered by Medicare will be forced to pay for medically necessary services out of pocket.

This is a particularly burdensome situation for beneficiaries living in rural communities. Most likely to be harmed are beneficiaries who have experienced a stroke or hip fracture or who have Parkinson's disease or other conditions that require extensive rehabilitation following injury or illness.

I urge the Chairman and Ranking Member of the Finance Committee to work with me and my colleague, the Senator from Nevada, on repealing this cap or at least suspending it for 1 or 2 years. My colleague and I have sponsored legislation (S. 569) to permanently repeal this cap. Our bill has

been cosponsored by 41 members of the Senate.

Again, I appreciate the opportunity to join my colleagues from Nevada today. It is my sincere hope, Mr. President, that we will be able to address the issue of the burdensome $1,590 cap on outpatient therapy services.

Mr. GRASSLEY. I thank both the Senator from Nevada and the Senator from Arkansas for their comments and for withdrawing the amendment. As you may know, I asked CMS Administrator Scully at the Finance Committee markup to further delay implementation of these beneficiary caps. Unfortunately, as a result of the Senate Budget Resolution constraints, I do not have Medicare dollars to repeal the beneficiary cap on therapy services. I agree that this arbitrary limit does not make sense and have sought to address this issue in the past. I will work in conference to enact a therapy cap moratorium and appreciate your hard work and passion on this issue.

Mr. ENSIGN. I appreciate the Chairman's leadership on this issue and I thank my colleague for agreeing, at a minimum, to work toward another moratorium on implementation of the therapy cap. I would also like to thank the Senator from Arkansas for her words of support. Mr. President, I yield the floor.

I ask unanimous consent that this full statement be included in the RECORD as if read.

Mr. HATCH. Mr. President, I strongly support Senator KYL's sense of the Senate resolution to S. 1. His resolution asks Congress to rectify problems with the formula that is used to update Medicare physician reimbursement.

Due to flaws in this formula, payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004. This cut in physician compensation would be the fifth since 1991 including a 5.4 percent decrease in 2002. According to Medicare's own conservative estimates, between the years 1991 and 2003, reductions for physicians and other health professionals resulted in Medicare physician reimbursement that equates to 14 percent below their actual practice costs. The 2004 reduction would decrease Utah physician income by $13 million which translates to $3003 per physician in 2004. And this is in addition to the $9 million decrease in reimbursement that Utah physicians received in 2002. Furthermore, unless we correct this formula, it is estimated that more cuts will occur in 2005, 2006, and 2007.

The Medicare Payment Advisory Commission, MedPAC, has stated that these reimbursement reductions are the result of a problem with the Sustained Growth Rate that is used as part of the calculation to adjust rates each year. The SGR expenditure target is linked to gross domestic product. Therefore, the formula may decrease Medicare reimbursement for physicians and other practitioners when health care volume increases outstrip increases in the gross domestic product. The problem is magnified when gross domestic product decreases. Essentially, the formula penalizes physicians for factors over which they have no control.

It is true that as the population of our country ages, the volume of Medicare health care services consumed increases. However, physicians have no control over this and our Medicare system penalizes them because of it. As a result, some physicians no longer take new Medicare patients, some decline to participate in the Medicare program altogether, and young people are considering other professions.

I would submit that as the baby-boomer generation ages and increasing numbers of Americans become Medicare beneficiaries, we need physicians and other health care providers more than ever. If anything, we should be rewarding our physicians, not penalizing them.

An additional problem with the Sustained Growth Rate calculation is that it does not account for many changes in health care that improve quality but increase physician work also. The federal government actively promotes new coverage decisions, quality improvement activities and other initiatives that benefit patients but are not taken into account by the Sustained Growth Rate calculation.

MedPAC's recommendation to Congress is that annual updates in physician payments should reflect increases in the Medicare Economic Index or MEI rather than the gross domestic product. Using the Medicare Economic Index would eliminate the penalty that physicians and other practitioners currently experience when the volume of health care services increases due to factors that they are unable to control.

What we have before us is a flawed formula that is threatening the health of Americans and the future of our country. Congress has addressed this problem before, but it seems that we were only putting a bandage over the wound; we never cured the disease that caused it. The wound continues to fester and it will continue to do so until we cure the problem. And the cure, it seems, is to revise the formula.

I for one, am tired of applying bandages to this wound. I believe that it is time to address this problem directly and definitively. I urge my colleagues to join with me in supporting this resolution and in working to correct this problem.

Mr. FEINGOLD. Mr. President, I joined my colleague, the distinguished Senator from Oregon, Mr. SMITH, in offering an amendment to promote better care for frail elderly and disabled. This amendment will allow the Secretary of the Department of Health and Human Services to designate health plans that disproportionately serve special needs beneficiaries as specialized Medicare Advantage plans.

A number of States have successfully chosen to serve seniors and the disabled by combining Medicare and Medicaid services through a waiver approved by the Department of Health and Human Services that integrates services under Medicare and Medicaid capitated financing arrangements. These programs provide beneficiaries with a comprehensive benefit package that combines the services traditionally provided by Medicare, Medicaid, and home and community based waiver programs.

In my home State of Wisconsin, the Wisconsin Partnership Program is one such success, a community-based program that has improved the quality, access, and cost-effectiveness of the care delivered to its beneficiaries. Perhaps most important to the beneficiaries, these programs help the disabled and the frail elderly remain in their own community, and avoid institutionalized care. Wisconsin is lucky to have four such programs across our State: Elder Care and Community Living Alliance of Dane County, Community Care for the Elderly of Milwaukee County, and Community Health Partnership Eau Claire, Dunn, and Chippewa Counties.

In order to qualify for these programs, a person must be Medicaid-eligible, have physical disabilities or frailties of aging, and require a level of care provided by nursing homes. Through programs such as the Wisconsin Partnership Program, these frail elderly and disabled beneficiaries are able to receive quality preventive care upfront, which allows more beneficiaries to stay in their communities and reduces the rate of hospitalization.

In Wisconsin, about 26 percent of all Medicaid recipients age 65 or older are in nursing homes. This rate drops dramatically for those enrolled in the Wisconsin Partnership Program, where only 5.9 percent of recipients age 65 or older are in nursing homes.

While the Wisconsin Partnership Program is a success, we must ensure that the Federal Government continues to support these State-based solutions to our long-term care needs and other specialty managed care programs that focus on frail, chronically ill seniors. Last year I introduced the Frail Elderly Act of 2002, which promoted specialty managed care programs and helped those already in existence to continue to operate. This amendment will work to accomplish both goals by providing a population-based designation that allows plans to be recognized for specialization in services for special needs beneficiaries. By establishing this specialized designation, we hope to be able to more easily move specialized plans from demonstration status to mainstream provider status, helping to promote a more effective way of caring for the frail elderly and disabled.

Mr. President I also want to point out that this amendment does not change payments, does not change administrative rules, and therefore doe not have a fiscal effect.

Fundamental long-term care reform is vital to any health care reform that

Congress may consider. As part of these reforms, we must support State and local efforts to encourage care for the most vulnerable populations. We must provide our seniors and disabled with real choices. They are entitled to the opportunity to continue to live in the homes and communities that they helped build and sustain. I urge my colleagues to support this amendment that will help provide a measure of support for the most frail elderly and disabled to allow them to stay in their own homes.

Mr. President, I ask unanimous consent that two letters of support for this amendment, from the Community Health Partnership and Elder Care of Dane County be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

COMMUNITY
HEALTH PARTNERSHIP, INC.,
Eau Claire, WI, June 26, 2003.

Hon. RUSSELL FEINGOLD,
U.S. Senate,
Washington, DC.

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Community Health Partnership, Inc. (CHP) is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WPP) is an integrated program of acute and long-term care services designed to improve access to needed care, reduce fragmentation of care across providers and settings, and help people remain independent in the community, while achieving cost savings. The target populations for WPP include both elderly and physically disabled individuals who meet nursing home level of care criteria. CHP serves both populations in a 3 county, rural area. Participants must be Medicaid eligible or dually eligible for Medicare and Medicaid services. A hallmark of this program is the use of an inter-disciplinary care team comprised of a physician, nurse practitioner and social worker that help coordinate beneficiaries' care across all health care settings. The WPP also participates in the Medicare/Medicaid Integration Program, a demonstration to test strategies for integrating Medicare and Medicaid services. The goal of this program is to create a seamless system of care for beneficiaries and to reduce costs related to duplication of services and administrative functions across programs.

Like a number of other specialty Medicare+Choice programs, the WPP currently operates under demonstration authority, which expires at the end of next year. And, like virtually all Medicare demonstration programs, there is no mechanism for transitioning from demonstration status into the mainstream of Medicare. I understand that The Medicare Prescription Drug and Reform Act of 2003 begins to address this problem by establishing a special designation for specialized Medicare Advantage plans that exclusively serve special needs beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that disproportionately serve special needs beneficiaries.

The expansion of the specialized Medicare Advantage designation would provide CHP and other WPP members additional flexibility in expanding our unique program to other beneficiary groups such as those who are eligible for Medicare, but not Medicaid and ''pre-duals''—those who are at risk of spending down to Medicaid based on health status and/or income limitations. Targeting healthy beneficiaries before they become frail or disabled would reduce long-run Medicare and Medicaid costs by preventing or delaying health care decline and the need for costly medical or long-term care services. Your amendment also would offer CHP a mechanism to serve non-special needs beneficiaries as a strategy for expanding our membership under a mainstream model or reducing our risk through a more representative cross-section of Medicare beneficiaries in West Central Wisconsin.

Your compassion for seniors, disabled and other special needs beneficiaries has been evident since you served as the Chair of the Senate Aging Committee in the State of Wisconsin. The amendment you are offering to the Senate Medicare bill only provides further evidence that you continue to be hard at work on behalf of Wisconsin's most vulnerable populations. Thank you for all of your work on behalf of Wisconsin's seniors.

Sincerely,

KAREN A. BULLOCK,
CEO.

ELDER CARE OF DANE COUNTY,
Madison, WI, June 24, 2003.

Hon. RUSSELL FEINGOLD,
U.S. Senate,
Washington, DC

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Elder Care of Dane County is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WWP) is an integrated program of acute and long-term care services designed to improve access to needed care, reduce fragmentation of care across providers and settings, and help people remain independent in the community, while achieving cost savings. The target populations for WWP include both elderly and physically disabled individuals who meet nursing home level of care criteria. Elder Care Partnership serves frail elderly beneficiaries. Participants must be Medicaid eligible or dually eligible for Medicare and Medicaid services. A hallmark of this program is the use of an inter-disciplinary care team comprised of a physician, nurse practitioner and social worker that help coordinate beneficiaries' care across all health care settings. The WWP also participates in the Medicare/Medicaid Integration Program, a demonstration to test strategies for integrating Medicare and Medicaid services. The goal of this program is to create a seamless system of care for beneficiaries and to reduce costs related to duplication of services and administrative functions across programs.

Like a number of other speciality Medicare+Choice programs, the WWP currently operates under demonstration authority, which expires at the end of next year. And, like virtually all Medicare demonstration programs, there is no mechanism for transitioning from demonstration status into the mainstream of Medicare. I understand that The Medicare Prescription Drug and Reform Act of 2003 begins to address this problem by establishing a special designation for specialized Medicare Advantage plans that exclusively serve special needs beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that disproportionately serve special needs beneficiaries.

The expansion of the specialized Medicare Advantage designation would provide Elder Care and other WWP members additional flexibility in expanding our unique program to other beneficiary groups such as those who are eligible for Medicare, but not Medicaid and ''pre-duals''—those who are at risk of spending down to Medicaid based on health status and/or income limitations. Targeting healthy beneficiaries before they become frail or disabled would reduce long-run Medicare and Medicaid costs by preventing or delaying health care decline and the need for costly medical or long-term care services. Your amendment also would offer Elder Care a mechanism to serve non-special needs beneficiaries as a strategy for expanding our membership under a mainstream model or reducing our risk through a more representative cross-section of Medicare beneficiaries in Madison.

Your compassion for seniors, disabled and other special needs beneficiaries has been evident since you served as the Chair of the Senate Aging Committee in the State of Wisconsin. The amendment you are offering to the Senate Medicare bill only provides further evidence that you continue to be hard at work on behalf of Wisconsin's most vulnerable populations. Thank you for all of your work on behalf of Wisconsin's seniors.

Sincerely,

KAREN MUSSER,
CEO.

Mr. HATCH. Mr. President, I rise to speak on the Gregg-Schumer amendment which was adopted last week. This amendment was based on a piece of legislation, S. 1225, the Greater Access to Affordable Pharmaceuticals Act of 2003, reported by the HELP Committee on June 11th.

I want to take this opportunity to explain why I cast the lone vote against this amendment. It is my hope that when my colleagues consider my explanation that they may be open to making additional changes to this very important amendment as the process moves forward.

Let me start by commending Senators GREGG, SCHUMER, MCCAIN, and KENNEDY for their work in developing this provision which I believe is a significant improvement on legislation that was adopted by the Senate last Congress, S. 812.

The Gregg-Schumer amendment relates to a complex and often admittedly confusing law I coauthored with my friend, Representative HENRY WAXMAN of California in 1984 the Drug Price Competition and Patent Term Restoration Act.

I chaired a hearing of the Senate Judiciary Committee in May of 2001 that helped document some abuses that were occurring in the law. Since our last hearing on this issue, much has happened.

Both the Federal Trade Commission and the Food and Drug Administration played a constructive role in attempting to end several mechanisms by which some research-based and generic

drug firms were attempting to game the system put in place by the 1984 and subsequent court decisions to avoid competition in the marketplace.

The FTC succeeded in achieving several widely-publicized consent decrees with a variety of offending firms under the existing antitrust statutes.

In addition, the FTC conducted an exhaustive survey and study of how certain provisions of the 1984 Waxman-Hatch Act affected competition in the pharmaceutical industry.

The FTC study contained two major recommendations. The first addressed the use of the statutory 30-month stay granted by the 1984 law in situations where patents are challenged by generic competitors. The FTC recommended that the law:

> Permit only one automatic 30-month stay per drug product per ANDA to resolve patent infringement disputes over patent listed . . . prior to the filing date of the generic applicant's ANDA.

This was precisely the position that I suggested in testimony before the HELP Committee on May 8, 2002 and argued for last year during the Senate debate on the Edwards-Collins substitute amendment to the McCain-Schumer legislation.

I would note that the 30-month stay provision in the McCain-Schumer bill last year, S. 812, and in the Edwards-Collins substitute, were both at variance with this central recommendation of the FTC report.

The second major FTC recommendation responds to those situations in which R&D and generic firms were entering into agreements not to impede generic competition. The FTC recommended that Congress:

> Pass legislation to require brand-name and first generic companies applicants to provide copies of certain agreements to the Federal Trade Commission.

Senator LEAHY, working very closely with the FTC, developed legislation, the Drug Competition Act, S. 946, that squarely addressed this second recommendation.

During the 107th Congress, I worked with Senator LEAHY on refining that bill. I supported it in committee, and worked with him to pass it through the Senate late last year. I supported his efforts to have it attached to the Medicare vehicle earlier this week. I expect that the 108th Congress will adopt this measure.

The FTC study served an important purpose of cataloging the facts surrounding certain abuses of the 1984 act. In formulating public policy, the facts should matter and a legislative or regulatory response should be tailored to fit the problem.

Unfortunately, the timing of the issuance of FTC study did not allow the report to get the attention it deserved by the Senate. The FTC report was published only one day before the Senate adopted S. 812, the Greater Access to Affordable Pharmaceuticals Act of 2003, last July 31st.

The GAAP Act, developed by Senators MCCAIN and SCHUMER, was substantially altered by the Edwards-Collins substitute, with active involvement of Senator KENNEDY.

While there is no question my colleagues were motivated by their goal of making drugs more affordable for seniors and all Americans, and despite the fact that it garnered 78 votes in the Senate, there were significant shortcomings in the bill.

Let me briefly review a few of the most troublesome provisions of the Edwards-Collins substitute to S. 812. The proposed legislation would have created for the first time a private right of action in the Federal Food, Drug, and Cosmetic Act. The last thing the already overburdened FDA staff needs is a bunch of trial lawyers bringing the agency to a screeching halt by second-guessing its judgment calls.

The bill that passed last year would have resulted in the waiver of patent rights apparently against even third parties—if pioneer drug firms did not file its patents with the FDA and, if challenged by a generic drug applicant, pursue expensive litigation within tight time frames.

In sharp contrast to the FTC recommendation, S. 812 basically made any patents listed with the FDA after a month from the date the pioneer drug application was approved by the FDA ineligible for the 30-month stay. In most cases, this is at least four years earlier than what I and the FTC recommended—freezing the Orange Book to patents listed before a generic drug application was filed.

The American Intellectual Property Law Association opposed S. 812. The patent-dependent biotech industry worked against the bill. The Patent and Trademark Office found that ''S. 812 would forfeit unnecessarily the core right of patent holders—the right to exclude others from practicing the inventions for the entire patent term. After years of research and development and significant investment, the patent right is extinguished for the mere failure to satisfy an administrative task or respond in a timely manner.''

Here is what the July 18, 2002 Statement of Administration Policy said about the Edwards-Collins-McCain-Schumer legislation:

> . . . the Administration opposes S. 812 in its current form because it will not provide lower drug prices. S. 812 would unnecessarily encourage litigation around the initial approval of new drugs and would complicate the process of filing and protecting patents on new drugs. The resulting higher costs and delays in making new drugs available will reduce access to new breakthrough drugs. Moreover, the new cause of action is not necessary to address patent process abuses. Clearly, the bill would benefit from consideration by the Senate's experts on Hatch-Waxman law on the Judiciary Committee, the proper committee of jurisdiction for this bill.

While S. 812 passed by a very wide margin, it was certainly not without its critics.

Comes now S. 1225. This bill emerged from the HELP Committee. Once again, it is entitled the Greater Access to Affordable Pharmaceuticals Act. Once again, it is cosponsored by Senators MCCAIN, SCHUMER, and KENNEDY.

Due in large part to the leadership of Chairman GREGG, there are significant changes in the bill compared with last year's legislation.

While I have significant concerns over certain aspects of S. 1225 as adopted in its amended form on June 19, 2003, I must acknowledge Chairman GREGG and Majority Leader FRIST for their roles in working with the cosponsors of last year's bill to make substantial improvements in the legislation.

Likewise, I commend Senators SCHUMER, MCCAIN and KENNEDY for abandoning many of the troublesome features of a bill that garnered 78 votes last Congress.

I can only believe that the factual presentation, analysis, and recommendations contained in the FTC report and subsequent public notice and comment process surrounding the recently-issued FDA final rule on patent listings and the application of the statutory 30-month stay both played a constructive role in helping to form the basis of the Gregg-Schumer legislation.

It is appropriate to recognize the efforts of the Bush administration for tackling the problem of multiple, successive 30-months stays through rulemaking. Secretary Thompson, Commissioner McClellan, and FDA Chief Counsel Dan Troy, should be saluted for their roles in so promptly completing a rulemaking regarding patent listing that generally embraced the one-and-only-one 30-month stay policy recommended in the FTC Report. Chairman Muris and the FTC staff deserve credit for a report that helped shape a more carefully targeted policy response.

There can be no doubt that this year's vehicle, S. 1225, is superior to S. 812. This new Gregg-Schumer bill, S. 1225, embraces exactly the type of one-and-only-one 30-month stay policy that I suggested to the HELP Committee last May, argued for on the floor last July, and was ultimately recommended by the FTC.

The Gregg-Schumer legislation, S. 1225 in the form adopted by the Senate, also addresses some problems that the FDA rule perhaps did not resolve satisfactorily. As FDA Chief Counsel Dan Troy stated at the June 17th Judiciary Committee hearing:

> We tried as best we could to cut down on all opportunities for gaming. We did not succeed in cutting down all opportunities for gaming, because nothing, no legislation is so good, no rule could be so good as to cut down all opportunities for gaming, because there are unforeseen circumstances and unintended consequences.

I think Mr. Troy is correct about the nature of the inherent limitations of regulatory and legislative fixes for complex problems where there are powerful incentives to game the system to gain financial advantage. We need to

keep this in mind as we analyze further the amendment the Senate adopted last week.

As I stated at the June 17th hearing, it was unfortunate that the PTO was unable to present a witness. Admittedly, the invitation was issued on short notice. I have asked PTO for its formal comments on the Gregg-Schumer amendment. I would also be interested in the PTOs comments on whatever language the House adopts. We would also be wise to hear from the Office of the United States Trade Representative if USTR finds that the legislation raises any concerns for international trade and intellectual property under the TRIPS provisions.

It is my understanding that FDA and FTC staff provided a great deal of what is known as ''technical assistance'' on the Gregg-Schumer amendment, a good deal of it between the markup on June 11th and the time the amendment was offered on June 19th. I am not aware whether PTO or USTR were consulted.

PTO and USTR should understand that this is a fast moving train, so they should be prepared to give us any comments they may have in short order. President Bush and the congressional leadership have made it plain that they expect the conference report on the Medicare bill to be completed as soon as possible.

One special area of concern to me as Chairman of the Judiciary Committee is that one provision of the amendment overwhelmingly adopted by the Senate raises significant issues with respect to civil justice policy, including a constitutional concern. Specifically, proposed section 271(e)(5) of title 35, would make the failure of a patentee to file a patent infringement action within a specified time frame sufficient to establish ''an actual controversy'' for the purpose of establishing subject matter jurisdiction for a declaratory judgement action by a generic drug firm challenging a patent.

Whether the Congress can, or should, by statute grant subject matter jurisdiction for a declaratory judgment based on the failure to bring a suit raises some interesting questions, particularly in light of manner in which the U.S. Courts of Appeals, including the Federal Circuit, have developed and applied the ''reasonable apprehension'' test. At our June 17th hearing, DOJ did not present the Judiciary Committee with its final opinion on the matter but Mr. Sheldon Bradshaw, Deputy Assistant Attorney General, Office of Legal Counsel, noted, ''that the actual case of controversy requirement is constitutionally compelled rather than statutorily required. And as a result, Congress can't simply create a case or controversy by statute but the plaintiffs must establish the constitutional requirement for bringing the case.'' The committee has received a spirited correspondence that takes differing views on the case or controversy provision of the Gregg-Schumer amendment.

I have requested the Department of Justice for its formal views on this language. At this point, I think it premature to embrace this language. It is my understanding that the bill that the House will take up does not contain the controversial case or controversy language. I stand prepared to work with the sponsors of the amendment, DOJ and others on this important issue.

Yet another improvement of S. 1225 over the bill adopted by the Senate last year relates to the manner in which the 180-day rule is addressed. In short, I am pleased that the policy embraced last year, the rolling exclusivity policy, was replaced in favor of a ''use it or lose it'' approach. I have long stated a preference for the consumer friendlier ''use it or lose it'' rule over the too open-ended rolling exclusivity.

The Waxman-Hatch law provides an incentive for generic firms to challenge patents. To encourage generic competitors to pursue patent challenges in a vigorous fashion, the 1984 law provided 180 days of marketing exclusivity in situations where a generic drug firm could show the pioneer's patents were invalidated or not infringed. For many years it was thought, as intended, that this valuable 180-day period of exclusive marketing would be granted to the first generic firm to successfully invalidate or invent around the pioneer's patents.

FDA regulations issued in 1994 required that the first generic applicant had to defend successfully against a patent claim made by a brand name company to receive the 180-day exclusivity. In a 1998 D.C. Circuit case, Mova v. Shalala, the court construed the plain language of the statute to strike down the successful defense requirement. As a result FDA now makes 180-day exclusivity decisions by applying the literal words of the statute. This results in a system that rewards first filers, not necessarily successful challengers.

The Gregg-Schumer amendment retains the preference for first filers. I believe that re-instating the successful defense requirement may prove preferable than intentionally sanctioning a first filer regime.

Frankly, I am uncertain of the policy justification for S. 1225's retention of granting the 180-day reward to the first filer rather than the first successful defendant. I believe that there is a lot to be said for giving the reward to the actual winner in court or the first not to be sued, not just the first one to enter the Parklawn Building with an application.

The amendment places a high premium on being a first filer. At our hearing last week, FTC Chairman Muris characterized the rush to be a first filer as ''the shantytown problem of people in line to file.'' FDA Chief Counsel Troy described that ''. . . right now, there are sometimes limousines, sometimes vans, sometimes cars, sometimes even tents in the Metro North parking lot that come days, weeks, and in some cases even months in advance of a particular date. Why we should reward someone because they camp out longer in the parking lot is a good question?''

I am concerned that the language that passed the Senate could allow some unintended and, in fact, counterproductive, results. Changes in current law with respect to the court decision and commercial marketing triggering mechanisms for the 180-day exclusivity provision demand careful attention and analysis. The amendment does not appear to adopt all the FTC recommendations in this area.

Other questions should be raised. What if, for example, the generic applicant that successfully challenges the validity of the patent is not also a first filer? Why should such a non-first filing but successful invalidity challenger not be granted the 180 days exclusivity? Stated another way, why should the first filer—or in Chairman Muris' ''shantytown'' situation, a whole group of first-day, exclusivity-sharing, first-filers, gain while the actual successful challenger waits out the 180-days? I am not sure that such an outcome is fair or even rational. Moreover, such a system may not result in the most efficient or aggressive pursuit of patent challenges.

One thing is for sure: You can expect a lot more first filers to appear at the door of the FDA building on the first day that successful drugs become eligible for patent challenges. As I pointed out at the Judiciary Committee hearing, some have already suggested that the first to file system might result in an increase in willful infringement cases. In fact, there was a decision last month by a Federal court in Chicago that ruled against a generic firm which filed a generic drug challenge before obtaining the opinion of outside counsel on either non-infringement or invalidity.

Another type of potential problem could arise, and frankly I am not certain how it can be avoided, if a non-first filing generic drug challenger wins a court decision on grounds of non-infringement. Unless I am wrong in my understanding of the Gregg-Schumer amendment, a generic challenger that prevailed on a non-infringement theory would have to wait for the 180-days granted the first filer, or a group of first-day, first-filers, to expire before the non-infringing firm could enter the market. Such an outcome only hurts consumers by needlessly delaying introduction of the non-infringing generic product for 180 days.

Unlike a determination of patent invalidity, a finding of non-infringement does not accrue to third parties. It is important to understand that there are two ways for a generic firm patent challenger to be awarded the 180-day exclusivity under the law. First, the generic challenger can show that the pioneer's patent is invalid. And second, the generic challenger can demonstrate

that its product will not infringe a pioneer's patent.

These are two very different theories. Al Engelberg, a highly successful and highly respected attorney engaged by generic drug firms to attack pioneer patents, has made the following observation about the difference between invalidity and non-infringement challenges:

In cases involving an assertion of non-infringement, an adjudication in favor of one challenger is of no immediate benefit to any other challenger and does not lead to multi-source competition. Each case involving non-infringement is decided on the specific facts related to that challenger's product and provides no direct benefit to any other challenger. In contrast, a judgment of patent invalidity or enforceability creates an estoppel against any subsequent attempt to enforce the patent against any party. The drafters of the 180-day exclusivity provision failed to consider this important distinction.

As one of the drafters of the 1984 law, I must accept a measure of responsibility for this problem. It is not clear, however, that S. 1225 has addressed this issue in a satisfactory fashion. The language adopted in the Gregg-Schumer amendment does not appear to solve the problem created by the 1998 Mova decision that effectively eliminated the successful defense requirement.

Frankly, I think we need further thought on how best to address the implications of the distinction between invalidity and non-infringement claims in the context of Hatch-Waxman patent challenges and 180-day exclusivity awards. Specifically, I question the appropriateness of continuing to group together patent invalidity and patent non-infringement challenges, particularly in light of the fact that the latter may in practice extend longer than the purported 180-day award. From what I know now, there are strong arguments to prefer the reinstatement of the successful defense requirement over the establishment of a new system based on first filing.

Let me close by once again commending Senators GREGG, SCHUMER, MCCAIN, and KENNEDY for all their hard work in reaching the compromise amendment that was so overwhelmingly adopted by the Senate. The Gregg-Schumer amendment represents significant improvement over the legislation passed by the Senate last year. I am pleased that the amendment adopts the one-and-only-one 30-month stay policy that I, and the FTC, advocated last year.

I am also pleased that the Senate has adopted Senator LEAHY's Drug Competition Act, which also addressed a major recommendation of the FTC. I have worked with Senator LEAHY to perfect and pass this measure.

As a co-author of the 1984 Drug Price Competition and Patent Term Restoration Act, I support efforts to bring affordable and innovative drugs to the American public. While I support the spirit and much of the letter of the Gregg-Schumer amendment, for the reasons I have set forth, I was unable to fully support this measure at this time.

Mr. BUNNING. Mr. President, during consideration of S. 1, an amendment was introduced by Senators SANTORUM and SCHUMER dealing with payments to the Medicare+Choice program. This amendment would have increased payments to the M+C plans over the next 2 years, to make sure they are still viable when the MedicareAdvantage program takes effect in 2006.

I realize the amendment was withdrawn because of the lack of funding in the Senate bill, but it is still an important issue I would like to lend my support to.

The Medicare+Choice program already provides a good prescription drug benefit to many seniors across the county, and gives these seniors another option to the Medicare fee-for-service program.

Unfortunately, many Medicare+Choice plans are pulling out of the program because their reimbursement levels are too low. This is leaving many seniors scrambling for a new Medicare+Choice plan or having to go back into fee-for-service Medicare which doesn't offer them the same types of benefits as their old M+C plan.

In fact, it seems like every year, more and more Medicare+Choice plans leave the market.

I am concerned if we do not provide these plans with enough funding over the next two years while the MedicareAdvantage program is being implemented, these M+C plans will continue to leave the program and more seniors will be left in the lurch.

This isn't fair to our seniors.

I had hoped we could provide some additional funding for the Medicare+Choice plans over the next 2 years so the plans currently in the program will remain and we might actually attract new plans to other areas that have not been served.

In Kentucky, we have a limited number of Medicare+Choice plans. In fact, only seniors in certain counties in Northern Kentucky and around Louisville have access to these plans. With higher payments to Medicare+Choice plans, we might actually get some more plans to come into our state and cover more counties.

We shouldn't give up on the Medicare+Choice plans, or the seniors enrolled in them. I hope this is an issue we can resolve during the conference with the House, and I commend Senators SANTORUM and SCHUMER for bringing this issue before the Senate.

Mr. LEAHY. Mr. President, I am pleased that late last night the Senate again supported lowering drug prices and maintaining a fair generic drug approval process by adding the Drug Competition Act of the Prescription Drug and Medicare Improvement Act of 2003, S. 1. Last November, the Drug Competition Act passed the Senate by unanimous consent. On Monday, Senator GRASSLEY and I, along with Senators CANTWELL, DURBIN, FEINGOLD, KOHL, and SCHUMER, offered our bill as an amendment to the larger Medicare bill. I hope that in this Congress it is actually enacted into law as part of the larger effort to improve the health care of millions of Americans. Prescription drug prices are rapidly increasing, and they are a source of considerable concern to many Americans, especially senior citizens and families. Generic drug prices can be as much as 80 percent lower than the comparable brand-name versions.

While the Drug Competition Act is small in terms of length, it is large in terms of impact. It will ensure that law enforcement agencies can take quick and decisive action against companies that are driven more by greed than by good sense. It gives the Federal Trade Commission and the Justice Department access to information about secret deals between drug companies that keep generic drugs off the market. This is practice that hurts American families, particularly senior citizens, by denying them access to low-cost generic drugs, and further inflating medical costs.

Last July, the Federal Trade Commission released to comprehensive report on barriers to the entry of generic drugs into the pharmaceutical marketplace. The FTC had two recommendations to improve the current situation and to close the loopholes in the law that allow drug manufacturers to manipulate the timing of generics' introduction to the market. One of those recommendations was simply to enact our bill, as the most effective solution to the problem of ''sweetheart'' deals between brand name and generic drug manufactures that keep generic drugs off the market, thus depriving consumers of the benefits of quality drugs at lower prices. Indeed, at a hearing just yesterday in the Judiciary Committee, Chairman Timothy Muris of the FTC praised the Drug Competition Act in his testimony and urged its passage. In short, this bill enjoys the unqualified endorsement of the current FTC, which follows on the support by the Clinton administration's FTC during the initial stages of our formulation of this bill. We can all have every confidence in the commonsense approach that our bill takes to ensuring that our law enforcement agencies have the information they need to take quick action, if necessary to protect consumers from drug companies that abuse the law.

Under current law, the first generic manufacturer that gets permission to sell a generic drug before the patent on the brand-name drug expires, enjoys protection from competition for 180 days—a head start on other generic companies. That was a good idea, but the unfortunate loophole exploited by a few is that secret deals can be made that allow the manufacturer of the generic drug to claim the 180-day grace period to block other generic drugs from entering the market, while at the same time, getting paid by the brand-

name manufacturer not to sell the generic drug.

Our legislation closes this loophole for those who want to cheat the public but keeps the system the same for companies engaged in true competition. I think it is important for Congress not to overreact and throw out the good with the bad. Most generic companies want to take advantage of this 180-day provision and deliver quality generic drugs at much lower cost for consumers. We should not eliminate the incentive for them. Instead, we should let the FTC and Justice look at every deal that could lead to abuse, so that only the deals that are consistent with the intent of that law will be allowed to stand. The Drug Competition Act accomplishes precisely that goal, and helps ensure effective and timely access to generic pharmaceuticals that can lower the cost of prescription drugs for seniors, for families, and for all of us.

The effects of this amendment will only benefit the effort to bring quality health care at lower costs to more of our citizens. The Drug Competition Act enjoyed the unqualified support of the Senate last year, and I am pleased that my colleagues have recognized that it fits well within the framework of the Prescription Drug and Medicare Improvement Act of 2003. It is a good complement to the larger bill and does nothing to disrupt the bill's balance. I sincerely hope that this commonsense legislation is a part of any final agreement with the House on the larger Medicare prescription drug bill.

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

● Mr. KERRY. Mr. President, I wish to express my enthusiastic support for the amendment Senators SCHUMER and SANTORUM offered to increase funding for the Medicare+Choice Program in 2004 and 2005. This amendment addresses a critically important issue that has far-reaching implications affecting the health care benefits of millions of low-income and minority seniors. I am pleased to be a cosponsor of this amendment to ensure that this urgently needed funding increase is included in the Medicare bill.

I believe we must take bold action to address the fact that Congress has not provided adequate funding for the health care of Medicare beneficiaries who select HMOs and other private sector health plans. In many parts of Massachusetts, and in other parts of the country, funding for Medicare+Choice plans has been limited to annual increases of only 2 percent in most years since 1998. These increase are inadequate at a time when health care costs are rising by 8 to 10 percent annually. This level of inadequate funding is unfair to the 170,000 Medicare beneficiaries in Massachusetts who have selected private health plan options. I am a strong supporter of the wonderful health plans we have in Massachusetts—Harvard, Tufts, Blue Cross/Blue Shield, and Fallon Community Health Plan. We must step up to the plate to help these plans—nonprofit plans in my State—in their time of need.

The Schumer-Santorum-Kerry amendment takes important steps to address this problem. By providing funding now to stabilize existing private health plan options for Medicare beneficiaries, we can help ensure that the proposed Medicare Advantage Program will be successful in the future. Our amendment lays the groundwork for successful long-term efforts to provide beneficiaries with high-quality health care choices.

As the Senate continues to debate changes in Medicare, it is important for us to remember that, for more than 4.5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high-quality, comprehensive, affordable coverage that is not always available, or affordable under the Medicare fee-for-service program. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because they recognize the value they offer.

Seniors in Massachusetts have come to rely on the high-quality health care they receive through their Medicare+Choice plans. Prescription drugs coverage, disease management services, physician exams, vision benefits, and hearing aids are examples of the additional benefits that are routinely offered by their Medicare+Choice plans.

These additional benefits are valued by all seniors, but they are particularly important to low-income seniors who cannot afford other Medicare supplementary plans that might provide them such benefits but at a greater cost.

As the Medicare debate moves forward, it is important for Congress to remember that Medicare+Choice serves as a vital safety net for many of our Nation's most vulnerable seniors. For millions of beneficiaries who cannot afford to purchase a Medigap policy, Medicare+Choice is their only hope for obtaining comprehensive health coverage.

The Schumer-Santorum-Kerry amendment focuses on protecting this important option for seniors who have nowhere else to turn for the quality health coverage they need. I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare+Choice Program for seniors. This should be among our highest priorities in this year's Medicare debate.●

Mr. CARPER. Mr. President, when I ran for the U.S. Senate, I promised Delawareans that I would work in a bipartisan fashion to provide a Medicare prescription drug benefit for our Nation's seniors. I pledged that I would seek consensus around what is right with competing Republican and Democratic plans. Along with my Democratic colleagues, I would support voluntary coverage that is available and affordable for all seniors. Along with my Republican colleagues, I would support choice and competition to constrain costs. And to the extent we found ourselves constrained by limited resources, I would seek to provide the greatest assistance to those with the greatest needs.

The bill before us today achieves some of that vision. It is bipartisan. It will provide a benefit available to all seniors on a voluntary basis. It will harness market forces to strengthen the integrity of the Medicare Program for the future. And it will provide comprehensive health security to our most vulnerable, low-income seniors.

Still, the bill we have before us today is not everything I would have hoped for. The overriding priority of the current majority here in Congress has been to make dramatic reductions in Federal revenues without corresponding reductions in Federal spending. As a result, there is insufficient money in the budget under which we are currently operating to provide the kind of comprehensive coverage that all seniors—not just low-income seniors—truly deserve. This is an unfortunate choice of priorities, I think, but it is the choice that this President and this Congress have made.

Unfortunately, the consequences of the majority's misguided priorities are evident in this legislation. When Medicare was created, the idea was to provide seniors with health coverage that was similar to the coverage available to most working Americans through their employers. This is what seniors expect when we say that we are providing them with a Medicare prescription drug benefit. However, the majority has only set aside for this bill about half of what it would take, according to the Congressional Budget Office, to provide seniors a benefit comparable to standard employer-provided coverage. Thus, there is a very noticeable gap in this bill's coverage, reflective of a substantial hole in our Nation's budget.

When seniors reach $4,500 in prescription drug costs, the coverage in this bill gives out. It does not kick back in until total spending reaches $5,800. It is widely acknowledged that this makes no sense. It makes no sense from an insurance perspective. It certainly is not reflective of the standard either in private employer-provided coverage or in the coverage provided to those of us who are fortunate enough to serve as Members of Congress. Nobody likes this gap in coverage. Nobody, so far as I can tell, defends it. However, because the root of problem is the majority's failure to set aside sufficient resources for this program, efforts to deal with the problem have only created new and potentially more serious difficulties.

For example, the authors of this legislation have attempted to narrow the coverage gap by not allowing employer contributions to count towards the calculation of seniors' out-of-pocket

spending in the gap. To see how this works, we need to understand how the coverage gap works. Once seniors reach $4,500 in total drug costs, they fall into the coverage gap. They then have to spend a certain amount of their own money—in the final bill reported out of the Finance Committee it is $1,300—before their coverage resumes, or they get out of the coverage gap.

The effect of not allowing seniors to count payments made by their retiree health plans toward this out-of-pocket requirement is to ensure that seniors will remain in the gap longer and fewer will get out of it. This allows the level of spending at which the gap ends to be set at a lower level than would otherwise be possible for the same budgetary cost. The problem with this, however, is that it also provides an unintended incentive for employers to drop or scale back their retiree drug coverage.

Thankfully, contributions from State prescription drug plans, like our Delaware Pharmacy Assistance Program, count toward the out-of-pocket requirement, which should encourage States to ''stay in the game.'' Employers, though, are effectively barred from wrapping their coverage around Medicare in the way that would be most beneficial for their retirees, which would be by filing Medicare's coverage gap.

In the course of our consideration of this legislation here on the floor of the Senate, I have urged my colleagues to address these shortcomings in the bill, even if that means reconsidering the majority's budget plan and the resource allocation for this program. I supported an amendment by Senator BOXER to eliminate the gap in coverage. And I cosponsored an amendment offered by Senator ROCKEFELLER to allow employer-provided coverage to wrap around the Medicare benefit and thus to eliminate the incentive for employers to drop coverage for their retirees.

The majority has made clear, however, that they are unwilling to reorder their priorities or to emplore the possibility of finding the necessary resources elsewhere in the budget to fix what they acknowledge are shortcomings in this legislation. Thus, the rest of us are left to choose between a prescription drug benefit that provides some, but not all, of the assistance that seniors deserve, or no prescription drug benefit at all.

Congress has been debating this issue for more than a decade. In many ways, it has been debating the issue since Medicare was first created back in 1965. I ran for the Senate in part because I was frustrated at the inability or unwillingness of the parties in Washington to come together to do what they could to solve problems and get things done. I am unwilling to walk away from the table this year with nothing for Delaware's seniors. They have waited too long and the need is too great.

In light of the budgetary priorities of the Republican majority, I am also very concerned about our future prospects. Should we let the present opportunity pass us by? I am concerned that if we do not act to get started with prescription drug coverage this year, even the limited resources that now remain may go out the door for other purposes—most likely another round of top-heavy, upper bracket tax cuts.

This is a first step. It is a downpayment. Just as I pledged when I ran for the Senate to work in a bipartisan fashion to get results, I pledge today to continue to work to build on these results. I continue to believe that we should provide our seniors with quality coverage without caps or gaps. I will work to ensure that filling the gap of coverage that exists in the present bill is given greater priority in future budgets than it was in this year's Republican budget. I also believe that it is a mistake to shun rather than welcome employer efforts to wrap around the new Medicare benefit, and I will work to rectify that mistake as we move toward implementation of this program over the next few years.

Mr. President, it is often said that politics is the art of the possible. The bounds of the possible are a bit narrower now than they need, thanks to our Republican friends. But, as the ranking member of the Budget Committee has said, this may be the best bill that could be written under the constraints of the Republican budget. For that reason, I commend the authors of this legislation—Chairman GRASSLEY and Senator BAUCUS, among others—for their work. I urge my colleagues to support this compromise as an important, if limited, first step toward addressing what clearly is a pressing priority, not just for our elderly population, but for our Nation as a whole.

Mr. JEFFORDS. Mr. President, as we debate the Prescription Drug and Medicare Improvement Plan of 2003, I would like to take a few minutes today to speak in support of the overall bill, but I would also like to highlight several provisions in the bill that are of particular importance to me and my State of Vermont.

Over the last several days, we have focused much of our discussion on the aspects of this bill related to prescription drugs and the Medicare Advantage Program. These are clearly among the most important provisions of this bill and these issues warrant the attention and debate they are receiving. I especially appreciate the close relationship this bill has to last year's tripartisan effort—which effectively is the parent of the current bill Last year, my friends—Senators GRASSLEY, SNOWE, HATCH, and BREAUX—and I set out to design a bill that provided a prescription drug benefit along with other improvements, what we called ''enhancements,'' to the basic operations of the Medicare Program. The tripartisan bill was good legislation—something all of its original cosponsors were very proud to work on together.

This year, I am pleased to say that the Grassley-Baucus bill is even better than our effort from last year, and I commend Chairman GRASSLEY and Ranking Member BAUCUS for their leadership and initiative in bringing it to the Senate floor.

One of the most important reasons that the Prescription Drug and Medicare Improvement Act is stronger than the tripartisan plan from last year is because it includes provisions that begin to resolve longstanding inequities in payments to rural doctors, hospitals, and other provisions. This problem can be stated simply. Rural health care providers are paid less than providers in more densely populated areas for the same exact services. Earlier this year, I joined with my colleagues, Senators HATCH, GRASSLEY, LINCOLN, and BINGAMAN, in introducing the legislation that addressed geographic inequities for physician services by changes to the physician reimbursement formulas.

As many of our colleagues are aware, Senator GRASSLEY fought to include these rural provisions in the recent tax bill that was signed by the President. And although I strongly disagreed with enacting further tax cuts, I was doubly disappointed to see the rural health provisions stripped out in the conference with the House. These unfair geographic differences in reimbursement rates have gone on far too long, and I am especially pleased to see reimbursement issues for rural providers getting the attention they deserve—including the commitment from the President to my friend from Iowa pledging his support for rural health relief as part of the effort we have underway. I am, therefore, very pleased to see that these provisions are included in the chairman's mark and are now part of this bill.

I am also glad that Chairman GRASSLEY and Ranking Member BAUCUS have worked with me to address another inequity in the system. Critical access hospitals provide care in the most remote regions of my State of Vermont and all other rural States. These hospitals are small, yet serve as critical resources to their communities. The managers have agreed to include a provision in their amendment that will make a technical correction to current law, allowing hospitals like the Mt. Ascutney Hospital in Windsor, VT, to expand access to psychiatric and rehabilitative services to the most vulnerable citizens in that community.

I would also like to speak today in support of a provision in this bill that establishes Medicare demonstration programs to improve health care quality. I heard my friend from Montana speak yesterday about quality and geographic disparities, and I know how committed he is to improving the quality of services delivered under Medicare. Earlier in this Congress, I was pleased that Senators FRIST, BEAUX, and GREGG joined me in introducing S. 1148, the Medicare Quality Improvement Act. I want to thank Chairman

GRASSLEY and Ranking Member BAUCUS for including this provision in this bill.

I became concerned about the issue of health care quality after reading the work of Dr. Jack Wennberg of Dartmouth, which has shown that higher levels of Medicare spending do not lead to better health outcomes. Let me repeat this finding. Higher levels of Medicine spending do not lead to better health outcomes. Instead, spending tends to vary by region—generally reflecting the availability of physicians and hospitals—rather than the health or needs of the population.

I have followed Dr. Wennberg's work for a very long time. One of his early studies looked at rates of surgical procedures at Vermont hospitals. He found that communities in Vermont that had many more medical procedures were not necessarily healthier. I saw how this result led Vermont health care providers to join with the business community in achieving high quality, supportable outcomes. I also saw how our State government used this effort to improve health care across our State. Today, I am happy to say that Vermonters enjoy some of the highest quality health care in the United States, at a cost that is among the lowest in the country.

As we prepare to vote for the bill before us, I think it is critically important for us to consider some of the lessons learned from Vermont. Some of my colleagues have expressed concern about the costs of the bill before us. Others have expressed concern that the bill does not go far enough. The quality demonstration program in this bill will give us some of the answers we need to these funding questions.

The need for these demonstrations is critical. RAND Health published a study today in the New England Journal of Medicine that describes the problems with overuse and underuse of needed medical care services in the United States. The RAND study will make it clear that every American is at risk—not only for failing to receive needed medical care, but also for receiving care that is not needed and may even be harmful. This is a problem that belongs to each and every one of us, and we must find ways to fix it.

The legislation before us closes a significant gap in the health benefit package available to our Nation's seniors. However, providing coverage for health care services is not enough. We must do a better job of ensuring that people are getting the care they need, and also that they need the care they get.

In closing, I would like to urge my colleagues from both sides of the aisle to support this bill as we move forward. This bill will establish a drug benefit that is universal, comprehensive, affordable, and sustainable. This bill restores necessary and long-needed fairness to our physicians and providers in rural areas. And, the bill will improve the quality of care offered under Medicare.

Mr. DORGAN. Mr. President, over the last 2 weeks the Senate has debated the most significant changes to the Medicare Program since it was created in 1965. Today, we passed this legislation by a 76 to 21 vote, and I would like to take a few minutes to explain why I supported this bill.

This bill will, for the first time, provide the option of modest prescription drug coverage for nearly 39 million Medicare beneficiaries, including about 103,000 beneficiaries in North Dakota. It is also intended to give Medicare beneficiaries more choices of health plans. And it takes significant steps towards equalizing the Medicare payments that rural health care providers receive, compared to their urban counterparts.

There is no question that, if Medicare were being created today, it would include prescription drug coverage. Prescription medicines are a vital part of modern medicine. Last year alone, pharmaceutical companies introduced 26 new prescription medicines into the marketplace. But these advancements in medicine mean little if Americans cannot afford to access them. That is especially true for senior citizens who have reached their declining income years.

For years now, Congress has been debating proposals to add a prescription drug benefit to Medicare. Unfortunately, however, in past years we have not been able to reach agreement on just how to do this. With each passing year, older Americans continue to struggle to pay for their medicine. In North Dakota, about 48,000 Medicare beneficiaries have no prescription drug coverage, and many more have limited drug coverage. I hear from North Dakota seniors regularly who tell me that they have to choose between taking the medicines their doctor prescribed for them and other necessities such as food and heat.

These older North Dakotans say that they want and need Medicare drug coverage, and they want and need it now. If Congress doesn't enact legislation this year, chances are that several more years will go by before there is another serious opportunity to consider this issue. In other words, we could pass the legislation before the Senate today or we could do nothing for yet another year. In my judgment, doing nothing is not an option.

The prescription drug benefit in this bill is not as helpful to seniors as I would like or as generous as I think Medicare beneficiaries deserve—but it is a start.

Frankly, I think our budget priorities have been wrong. If I had my way, Congress would have reduced the size of the tax cuts for the very wealthy and instead set aside more money for improving and modernizing Medicare. During the Senate's debate earlier this year on the budget, I offered an amendment to set aside a total of $620 billion over the next 10 years for a Medicare prescription drug benefit. This is the amount of funding I felt was needed to provide a more generous and reliable benefit. Unfortunately, the majority in the Senate rejected my amendment, so we are limited to a package of just $400 billion over 10 years. When you consider that Medicare beneficiaries are projected to spend $1.8 trillion on prescription drugs over the next 10 years, it is impossible to develop a robust benefit within the $400 billion budget constraint, in my judgment.

The benefit provided for in this legislation is better than that which President Bush proposed in several key respects. Most importantly, this bill will not force seniors to leave the traditional Medicare Program—and the doctors they depend on—in order to get the prescription drug coverage they also need. I could not support a bill that coerces seniors out of the traditional Medicare Program that virtually all of North Dakota's Medicare beneficiaries rely on.

In addition, this bill provides extra assistance above the basic drug benefit for those older or disabled beneficiaries who have low incomes or very high drug expenses. Medicare beneficiaries with incomes below about $14,400 for individuals and $19,400 for couples—about 40 percent of North Dakota's beneficiaries—would qualify for extra assistance. And those with the highest drug costs—totaling more than about $5,800—would qualify for the catastrophic drug coverage. About 7 percent of North Dakota Medicare beneficiaries would reach this threshold.

Despite these improvements over the President's proposal, there are other concerns that I worked to address during the Senate's debate. In some instances, we were able to make changes to address these concerns, and in other cases, those efforts were rejected. In those instances where concerns still exist, I intend to continue working to fix them in conference with the House of Representatives.

For instance, as I have already mentioned, I am concerned that this coverage is not as generous as it should be, and in fact, there are some holes in the coverage. Under this benefit, seniors will have to reach a $275 deductible before their Medicare drug coverage starts. In addition, seniors whose drug expenses reach $4,500 will have to pay 100 percent of their drug costs between $4,501 and $5,800. Then, when their drug spending reaches $5,800, the catastrophic drug coverage will kick in and Medicare will pay 90 percent of their drug expenses after that. This means that there could be periods—in some cases as much as 3 months—when Medicare beneficiaries will have paid a premium for drug coverage but will be getting no benefit.

That makes no sense to me. No other insurance plans that I am aware of include such gaps in coverage. I supported various amendments on the Senate floor to close these coverage gaps or at least ensure that seniors

don't have to pay premiums for the periods when they aren't receiving coverage. Regrettably, however, those efforts were rejected.

I am also concerned that rural Medicare beneficiaries may not receive a benefit that is as stable or as generous as other beneficiaries receive. This bill envisions that seniors will basically have two options for receiving drug coverage. First, this bill creates a new Medicare Advantage Program through which beneficiaries could choose to get their drug coverage, as well as the rest of their medical care, through an HMO or a PPO. Frankly, however, I am very skeptical that HMOs or PPOs will want to serve rural areas, and even if they do, I don't think most North Dakota beneficiaries will want to leave the traditional Medicare Program.

Those seniors who want to remain in the traditional Medicare Program will be able to do so and get their prescription drug coverage through private ''drug only'' insurance plans. Budget experts estimate that Medicare beneficiaries who sign up for these drug-only plans will pay an average monthly premium of about $35. However, this is only an estimate, and the actual premium that seniors pay could vary substantially from area to area. That is already the case in the current Medicare HMO program—for instance, a Medicare HMO with drug coverage currently charges $99 per month in Connecticut and only $16 a month in Florida. I am worried that it would be rural seniors who would pay the highest premiums, even though they paid the same Medicare payroll taxes as other beneficiaries.

To address this concern, I supported an amendment by Senator DASCHLE that would have limited the variation in premiums to only 10 percent above the national average, no matter where beneficiaries live. In other words, insurance companies could charge beneficiaries a lower premium but they couldn't charge them more than 10 percent above the national average. Unfortunately, however, Senator DASCHLE's amendment was rejected.

In areas where there are not at least two private drug-only plans offered to Medicare beneficiaries in any given year, Medicare would step in and ensure that there is a ''fallback'' plan available. This is a vital guarantee for beneficiaries in rural States like North Dakota where I believe it is unlikely that there will be two stable drug-only plans available. But even with this fallback plan, seniors could still be bounced back and forth between different plans, depending on how private plans move in and out of an area.

I supported an amendment that would have addressed this concern by allowing all Medicare beneficiaries to choose the fallback option, no matter how many private plans are available where they live. When that amendment failed, I cosponsored an amendment with Senator CONRAD that would at least allow seniors who have the fallback option to remain in that plan for 2 years, not just 1 year. That amendment was also rejected.

Even though this bill doesn't require Medicare beneficiaries to leave traditional Medicare, I know there are some concerns that Medicare beneficiaries will be getting their drug coverage through private plans. I, too, would strongly have preferred that all seniors be able to choose from a Medicare-administered benefit.

However, let me say this if I felt that by structuring the drug coverage the way it is in this bill, we were undermining the entire underlying Medicare Program, I would not support it. Medicare has been a wonderful success, and in our efforts to modernize it, we should exercise extreme caution not to undermine it. However, virtually all of the major Medicare prescription drug proposals would have used a private entity in some way to provide the drug benefit. Indeed, the traditional Medicare Program currently contracts with private insurance companies to pay the millions of Medicare claims that come in each year. Furthermore, the Congressional Budget Office estimates that only 1 to 2 percent more beneficiaries will choose the new Medicare Advantage option, so it seems clear that the vast majority of seniors will continue to rely on the traditional Medicare Program for the bulk of their medical care.

One area where we had some success in improving the bill during the Senate's debate is in the area of reducing drug costs. This bill relies largely on private insurance companies to negotiate lower drug prices. However, we have seen from prior experience that insurance companies have not been able to keep drug spending from increasing by nearly double digits every year 9.7 percent in 2002, 17 percent in 2001, 18.8 percent in 2000, and 16 percent in 1999.

To help put downward pressure on drug prices, I offered an amendment that was passed by the Senate by a 62-to-28 vote to allow for the reimportation of lower-priced, FDA-approved medicines from Canada. As many North Dakotans know first hand, the same FDA-approved prescription drug that costs $1 in the United States costs only 62 cents in Canada, even though it is the exact same drug, in the same bottle, made by the same manufacturer.

It is not my intention with this amendment to require Americans to go to Canada in order to get lower drug prices. Rather, by allowing U.S. licensed pharmacists and drug distributors to do the importing for them, Americans can stay at home, and by breaking the monopoly that the drug companies currently have on drug pricing in this country, we will force a repricing of drugs here in the United States.

I also supported an amendment that will help to make more affordable generic drugs more readily available. Generic drugs are safe, effective, and lower priced alternatives to heavily advertised brand-name prescription drugs. Unfortunately, however, some of the big brand-name drug companies use loopholes in the patent laws to keep generic drugs off the market for longer than intended. This amendment, which passed the Senate by a 94-to-1 vote, will close these loopholes and thereby speed consumers' access to generic medicines.

I am also pleased that this bill improves Medicare's coverage of preventive services, especially by including a provision that I authored to provide for a cholesterol screening benefit for Medicare beneficiaries. I have felt for a long time that Medicare needs to do a better job of preventing disease, rather than just paying to treat it. In the case of cholesterol screening in particular, high cholesterol is one of the major, changeable risk factors for heart attacks, stroke and other cardiovascular diseases. Yet when Americans turn 65 and enter the Medicare Program, their coverage for cholesterol screening stops unless they already have cardiovascular disease. That makes no sense, and I am glad the Senate has taken steps to provide this coverage.

Finally, I am very happy that this bill includes a range of provisions that will make Medicare reimbursement more fair and equitable for our rural hospitals, physicians, and other health care providers. It is simply not right that Medicare has historically reimbursed urban health care providers at a much higher rate than their urban counterparts. This inequity in Medicare reimbursement has very real consequences for hospitals and clinics in rural States like ours. They have to reduce services, have greater difficulty recruiting staff, are less able to make capital improvements, struggle to give their patients access to the latest innovations in medical care, and in same instances, they even have to close.

I have been fighting for a long time to correct this inequity. In fact, some of the provisions in this bill are similar to legislation that I introduced in the Senate earlier this year, and I am glad they have been included in this bill.

I know there will be some who feel that this bill should have been rejected by the Senate because it relies too heavily on private plans and others because it does not place enough emphasis on enrolling seniors in private plans. Others will feel that the Medicare benefit is not generous enough, and some feel its coverage is too liberal. I agree that this legislation isn't perfect—far from it, in fact. In the coming months and years, I will continue working to improve it. But it is a start in the right direction, and that is why I have supported it.

The House of Representatives is also expected to pass its version of Medicare legislation this week. The House and the Senate will now need to have a conference committee to work out the differences between the two bills. I

have some serious concerns about the House-passed bill. I hope these concerns and the concerns that I have with the Senate bill can be resolved in the final bill, so that we can send a bill to the President for his signature this year.

Mr. SARBANES. Mr. President, I rise today to speak on S. 1, the Prescription Drug and Medicare Improvement Act of 2003. I applaud my colleagues in working toward enactment of legislation to provide prescription drug coverage under Medicare. However, I am deeply concerned that the bill before us today would not ensure an affordable, guaranteed benefit that would cover seniors' outpatient prescription drug expenses.

Under this legislation, the Secretary of the Department of Health and Human Services would temporarily issue prescription drug discount cards for seniors until the drug benefit begins in 2006. At that time, all Medicare beneficiaries would receive a standard prescription drug benefit whether they remained in traditional fee-for-service or in a private plan. For a $275 deductible and an estimated $35 per month, 50 percent of a beneficiary's drug costs would be covered up to $4,500. A beneficiary would receive no coverage for drug costs between $4,501 and $5,800, though they are still responsible for paying the monthly premium during this coverage gap. Furthermore, any assistance provided by employer-sponsored plans or third parties on behalf of the beneficiary does not count toward the out-of-pocket costs. After drug expenses reach $5,801, the plan would cover 90% of drug expenses.

The bill creates a new Medicare Advantage program, which would replace Medicare+Choice, and create a new agency, the Center for Medicare Choices, CMC, with authority parallel to the existing Centers for Medicare and Medicaid Services. The CMC would administer the Medicare Advantage program and the prescription drug plans. The drug plans would be administered through private plans, but when no private plans exist, the government would provide a fallback plan for seniors in fee-for-service. However, if a new private plan decides to enter an area, beneficiaries would again be forced to receive their coverage through that plan.

If this sounds terribly confusing, it is. One hundred Senators and their staffs found it difficult to work through this bill and understand exactly how the benefit would work. Seniors who don't sign up as soon as they are eligible are subject to a penalty similar to the penalty imposed on those who delay enrollment in Part B. It is unfair to expect seniors and their families to work through this web to make an informed decision.

The complexity of this drug plan is only one of numerous flaws with this bill. S. 1 does not provide a national fixed premium. The bill sets out an estimate of a $35 monthly premium, but there is no guarantee for seniors that they will not have to pay much more than that estimate.

The bill has the serious potential to cause a number of retirees to lose existing employer-sponsored prescription drug coverage. CBO estimates that as many as 37 percent of Medicare beneficiaries would lose existing coverage. This is an unacceptable consequence of legislation that is supposed to make life easier for seniors. This serious deficiency is the number one concern of constituents who have called into my office about this bill.

The bill before us leaves a large gap in coverage and forces seniors to continue premium coverage during that gap period. Seniors may have to face months without any assistance, waiting to reach the limit where catastrophic coverage begins. The seniors who fall into this coverage gap are among the most ill, with severe chronic conditions and prescription needs. It is difficult to support legislation that would cease coverage for prescription drugs for seniors at the very time when it is needed most.

Finally, because this proposal relies on private plans to deliver the drug benefit, seniors could be forced to shift from plan-to-plan, year-to-year as they did when Medicare+Choice HMOs pulled out of the Medicare program a few years ago. In my own State of Maryland, insurance companies left the Medicare program, abandoning more than 100,000 seniors.

This legislation makes our Nation's seniors the subject of an experiment to which none of us should be willing to subject our parents and grandparents. We don't know what the benefit is under this bill. We don't know how much it will cost. We don't know how private plans will participate and make a profit. We don't know how many seniors would lose existing coverage. What we know is we are prepared to spend approximately $400 billion over 10 years to create an inadequate drug benefit, a new bureaucracy, and subsidies for private insurance companies.

With modest additional resources, we could have closed the coverage gaps in this bill. Amendments offered by my colleagues to provide stability for seniors, move up the start date of the drug benefit, eliminate beneficiary premiums during the coverage gap period, and improve a variety of shortcomings have been defeated. We have lost so many opportunities to make this bill something all Medicare beneficiaries can support. I am hopeful that in the future we can improve upon this and create a system that is easier for seniors to understand, more affordable, and more reliable than what is offered today.

I want to highlight one amendment that would have provided Medicare beneficiaries with a substantial, reliable and straight-forward prescription drug benefit. I cosponsored and voted for this amendment offered by my colleague from Illinois, Senator DURBIN. His alternative would have provided a Medicare-delivered drug benefit that allows the Secretary of HHS to employ negotiating strategies used by the VA and other government entities to bring down drug prices. Under Senator DURBIN's plan, seniors would have no deductible, pay only 30 percent of costs until reaching the catastrophic limit, and face no coverage gap. In addition, employer contributions would count toward out-of-pocket limits so there would be much less risk of employers dropping retiree coverage. This was the proposal we should be working from today, but unfortunately the Durbin alternative was defeated by a vote of 56 to 39.

Those opposed to providing a richer benefit argue we don't have the money. The selective amnesia of these so-called fiscal conservatives is baffling. Not too long ago, this body passed a tax cut that primarily benefited the wealthiest Americans. Where was their sense of fiscal responsibility then? As my colleagues Senators DURBIN and HARKIN noted yesterday, this is about priorities. I'm sure others have raised this very good point as well. We can risk greater budget deficits to give huge tax cuts to Americans who are already prospering, but we cannot provide the necessary resources for millions of Medicare beneficiaries to get an affordable, reliable drug benefit that they can understand?

I have long been a strong supporter of providing older Americans and disabled individuals who rely on Medicare an affordable, comprehensive, reliable and voluntary prescription drug benefit. However, I want to ensure we do so in a way that does not worsen the situation in which many seniors find themselves as they face rapidly rising drug costs. As we consider proposals to expand our Nation's major health entitlement programs, it is appropriate to follow a guiding principle in the practice of medicine—do no harm. Our seniors deserve a drug benefit that is a real improvement, not a complex experiment that may cause more trouble than it's worth. We must not enact a law intended to help that might eventually harm millions. The American people deserve better.

Mrs. BOXER. Mr. President, for over 35 years, Medicare has been a savior for our seniors citizens. It has helped pay their doctor bills, their hospital bills, and their home health bills.

But it has not paid for their prescription drug bills, and millions of seniors across the country have been waiting a long time for the day when prescription drug coverage is offered through Medicare. That day is getting closer.

I am supporting—and the Senate will soon pass—a Medicare prescription drug benefit.

Let me tell you why this is important. In California, four million people are enrolled in Medicare. Every day, far too many of them are forced into the difficult choice of paying for their prescriptions or putting food on the table.

I want to tell you a few of their stories.

I recently heard from a California woman who told me she struggles to survive on $950 a month income. She cannot, she says, afford all of her prescription drugs. She is, unfortunately, all too typical.

A constituent from San Marcos, CA told me that her annual costs for prescription drugs this year will top $10,000.

Another constituent from Indio, CA told me that she has made five trips to Mexico over the last several years to purchase her prescriptions. She drives all day long to Mexico in order to purchase affordable heart medication. She wanted me to remind my colleagues that ''thousands of seniors are forced to do this.''

A retired physician from Marina Del Rey told me that a pill he takes for his heart disease has gone up 600 percent from $15 per month to $85.

These seniors—all of our seniors—need and deserve to have Medicare help pay for their prescription drugs. We need to end this situation where seniors are cutting their pills in half or forgoing their medications altogether or skipping meals in order to pay for their prescription drugs. That is unacceptable.

Today, we are making a prescription drug benefit a part of Medicare. And that is why I am supporting this bill—because, at long last, it puts a Medicare prescription drug benefit on the books.

But, this bill is wanting. It has problems. And I have voted for amendment after amendment to fix those problems.

I offered an amendment to close the benefit shutdown. Under this bill, even when seniors have paid and continue to pay premiums, Medicare stops covering prescription drugs, forcing seniors to pay the entire cost. When that failed, I offered an amendment to ensure that seniors with cancer would never have their benefit stopped.

I supported an amendment by Senator STABENOW to ensure that all seniors could get prescription drug coverage from Medicare itself—the tried and proven system—rather than from a private insurance company.

I supported an amendment by Senator GRAHAM to stop charging seniors premiums when they are not getting any benefits.

I supported an amendment by Senator LAUTENBERG to start this benefit next year not 2 and a half years from now.

I supported an amendment by Senator DODD to encourage employers not to drop their retiree health coverage so seniors who have good coverage can keep it. And the Levin amendment, which I also supported, would have ensured that if employers did drop such coverage, Medicare would be there to provide prescription drugs.

I supported an amendment by Senator DORGAN to reduce the premiums that beneficiaries must pay each month. And I supported an amendment by Senator DASCHLE to limit the disparities in premiums so that seniors in different parts of the country are not paying different premiums for the same benefit.

These amendments would have made the Medicare drug benefit a better drug benefit for seniors. Unfortunately, none of them passed.

But we should not—and I will not—stop trying to make it the best benefit it can be.

The good news is that Medicare will soon, for the first time ever, cover prescription drugs. The better news will be when we fix the problems with this bill and improve the coverage for our seniors. I look forward to the day when enough of my colleagues will join me in that effort.

Finally, let me say that I hope the conference report on this bill—the final version of the bill before it goes to the President—does not come back to the Senate in a way that would provide even less help to seniors or in a way that would undermine the entire Medicare program.

Ms. MIKULSKI. Mr. President, senior citizens are facing a crisis—a crisis in affording health care and a crisis in affording prescription drugs.

I have been in communities all over Maryland. Listening to seniors who are desperate. Listening to their families in the diners—who want to help their parents, yet face stresses of their own. Listening to the employers in the boardrooms—who want to help their retirees, but can no longer afford to.

Here is what they tell me. They say: We need a prescription drug benefit in Medicare. We need a safety net for seniors and families. Congress must enact a Medicare prescription drug benefit, and must do it now.

I absolutely agree. It is time Congress made Medicare prescription drug coverage a national priority.

For so many years, Congress has talked about prescription drugs and Medicare. Talk, talk, talk. You can't talk yourself out of high cholesterol; you need Lipitor. You can't talk your way out of diabetes; you need insulin.

The problem with the Senate is—when all gets said and done—more gets said than gets done. Finally—the Congress is acting.

Here are my principles. These principles are the yardstick by which I measure any proposal.

The benefit must be for seniors, not for insurance companies. That means the cornerstone must be Medicare. This bill does that. It does not force seniors to give up the Medicare they love to get the drugs they need.

It must help the majority of Marylanders. I work for Marylanders. So I did the numbers—570,000 Marylanders are on Medicare. According to Johns Hopkins, 68 percent of these seniors would benefit from this legislation. That means 394,000 would benefit from this bill.

It must be voluntary. And the answer is, yes, this bill is voluntary. No one should be coerced or forced into a private program or forced to give up coverage they currently have.

It must be affordable. I am not so sure. I am concerned about the significant deductible—$275 a year and the hefty premiums—almost $400 a year. It also has a coverage gap. Once you spend $4,500 a year—you get no help until you spend $5,800. This will cost too much. That is why I supported the Durbin amendment, which would have provided a better benefit at less cost to seniors.

It must be accessible. It must be available to all seniors, regardless of where they live. This bill does that.

It must be meaningful. It must cover the kind of drugs your doctor says you need, not what an insurance executive thinks you should get. This bill does that by creating a medical necessity override. This means your doctor has the final say on which drugs you get, not an insurance company. I feel pretty good about that.

I tried to improve the bill. I voted for amendments to improve the bill. For example: For the Durbin substitute which would have created a stronger, more comprehensive benefit at a lower cost to seniors.

For an amendment to get rid of the coverage gap. This would guarantee that seniors would have continuous coverage for their prescription drug costs.

For an amendment to provide seniors with a guaranteed prescription plan that is under Medicare. This would allow seniors to stay in a prescription drug plan that is operated by Medicare and not have to move in and out of private plans and a Medicare fallback plan that is only available when the private plans leave the market.

For amendments to protect the benefits of retirees who already have drug coverage. These amendments would help employers to continue to be able to offer quality health care to their retirees.

For an amendment to implement the drug benefit next year—instead of waiting until 2006 to start these benefits.

I am sorry all these amendments failed on party line votes.

This legislation is a beginning. It is something we can build on. What it comes down to for me is—will it help the majority of seniors in Maryland? The answer is, yes; it will help over 394,000 people. For people who spend at least $1,110 a year on prescription drugs—it will help. For someone who is facing a catastrophic disease like cancer and has very high drug costs—it will help. So I will vote for this bill. It is not the bill I want. Yet we can't let the perfect be the enemy of the good. We can't do nothing—as seniors struggle to pay for the drugs they need.

But let me be very clear, this is as far as I will go. If this bill comes back from conference and it is a benefit for insurance companies—say goodbye to my vote. If it increases costs for seniors, say goodbye to my vote. If it cuts benefits, say goodbye to my vote.

So I will vote for this legislation tonight because I don't want to say goodbye to this opportunity to provide a Medicare prescription drug benefit for seniors.

Mr. HOLLINGS. Mr. President, I rise today in opposition to the Prescription Drug and Medicare Improvement Act of 2003.

The Senate has spent the last 2 weeks debating how to help our Nation's senior citizens afford their prescription drugs. The Kaiser Family Foundation estimates that average annual out-of-pocket drug spending for Medicare beneficiaries grew from $644 3 years ago to $999 this year and will reach $1,454 by the time this bill takes effect in 2006. As a result, 25 percent of seniors without drug coverage declined to fill a prescription and 27 percent of seniors without drug coverage skipped doses to make their prescriptions last longer. This is unacceptable. These citizens deserve affordable, comprehensive, and reliable drug coverage. Unfortunately, the legislation now before us fails to provide sufficient coverage.

From the outset this proposal will confuse seniors. Enrollees in private plans better not get too comfortable because their plans could be gone in 2 years if the HMOs find them unprofitable just like they have with Medicare+Choice in my state of South Carolina. The same goes for enrollees in fallback plans. They will be kicked out of their plan in as early as a year if enough private plans enter their area. This volatile system could force seniors to move in between three separate plans, with three separate formularies, in 3 years. This bill should create a sense of stability in the system and reduce the confusion over coverage. That is why I supported first the Stabenow amendment and then the Lincoln-Conrad amendment, which would have extended the availability of fallback plans to ensure that seniors will have access to stable drug coverage.

Senior citizens will need to hire an accountant just to comprehend the benefits available to them under this legislation. Once seniors select their Medicare drug plan, they will have to maneuver a maze of premiums, deductibles and copayments for benefits that contain huge gaps in coverage. On top of their premiums, which will vary from region to region and plan to plan, seniors will get no help for the first $275 of their drug costs, pay half of costs from $276 to $4,500, pay all the costs from $4,501 to at least $5,813, and then pay a tenth of costs above $5,288. With a breakeven point of $1,115, many healthier Medicare beneficiaries will opt not to participate. With a coverage gap of $1,302, many of the sickest patients will still have to continue paying premiums even though they may have to resort to rationing their care until they can spend their way out of the ''doughnut.''

Once again, the Senate defeated a number of amendments that I supported that would have brought much needed simplicity and fairness to the bill including the Boxer amendment, which would have closed the coverage gap for all seniors, and the Daschle amendment, which would have limited the regional variation among premiums to 110 percent of the national average. Finally, we chose to provide $13 billion in new subsidies to PPOs and HMOs instead of using that money to reduce premiums or fill in the coverage gap for cancer or Alzheimer's patients. All in all, the bill provides Medicare beneficiaries with a benefit valued at about $1,000 less than the drug coverage available to Federal employees.

This is a plan only Washington could dream up. It should come as no surprise that the authors of this convoluted mess and their friends in the White House have decided to wait until after the 2004 election before allowing Medicare beneficiaries to see what they are in for.

I should also note that this Nation is more than $6.6 trillion in debt. This bill is part of budget resolution and economic plan that will run up an average deficit of $600 billion a year for the next 10 years. Make no mistake about it, we will borrow every red cent to pay for this program. And what do we get in return? Massive subsidies for HMOs, spotty drug coverage for senior citizens, and a lack of attention to the factors driving the rapid increase of health care costs in this country. If we are going to borrow from future generations to pay for this benefit, we should get it right.

Now that we have disposed of all amendments and final passage appears imminent, I have concluded taxpayers and Medicare beneficiaries would be better served if we go back to the drawing board. We should come back with a proposal with affordable premiums and cost sharing requirements with no gaps in coverage that is administered in a manner that gives seniors the same sense of security they receive under the current Medicare program. I have heard many of my colleagues say this is an important first step and it is important that we get something on the books. Nonsense. Thirty months will pass before the first beneficiary receives coverage. That was enough time to draft and ratify the Constitution. It was enough time to complete the Manhattan Project. Thirty months should be more than enough time for us to create a real, meaningful prescription drug benefit for our senior citizens.

I hope this body will have the wisdom to vote no and do this right.

Mr. FEINGOLD. Mr. President, I will vote for passage of the Medicare prescription drug bill that has been debated over the past several weeks.

I do so, however, with great reservations about many of the provisions in the bill.

I am voting for this measure for two principal reasons.

First, I believe that we owe our seniors a Medicare prescription drug benefit. I believe such a benefit is long overdue for our Nation's seniors. For years we have promised them we would give them the crucial help they need with their skyrocketing prescription drug costs. And I believe that it is finally time to deliver on that promise.

It has taken Congress too many years to act on this pressing need. We have been debating for years about the best way to provide this benefit, and I am afraid that if we do not take the opportunity in front of us today, it will take us even longer to provide seniors the help they deserve. Our seniors cannot wait any longer.

The costs of prescription drugs are soaring, and the financial toll they take on our seniors means that too often seniors must choose between eating and taking the medication that will help them live productive, healthy lives. Our seniors should not have to make that choice. They contributed to the Medicare system over their lifetimes. That system, which is supposed to provide health care to all seniors, needs to be able to help them obtain the prescription drugs they need to preserve their health.

The second reason I am voting for this benefit is that it takes a big step in addressing what I see as one of the biggest flaws of the current Medicare system—the geographic inequities within the Medicare reimbursement system. We need to end Medicare's continued discrimination against Wisconsin's seniors. As I have previously discussed on this floor, Wisconsin seniors already receive the short end of the stick when it comes to Medicare. Wisconsinites pay the same payroll taxes to Medicare as all American workers do, but receive fewer benefits in return. Instead, Wisconsinites' Medicare dollars are used to subsidize higher reimbursements in other parts of the country.

Wisconsin Medicare beneficiaries receive on average $4,318 in Medicare benefits per year, the eighth lowest in the country. By contrast, beneficiaries in the State with the greatest per capita reimbursement receive $7,209. This distribution of Medicare dollars among the 50 States is grossly unfair to Wisconsin. I thank the leadership of the Finance Committee for including provisions to begin to address this inequity in this prescription drug bill. But I know that we still have more to do to reverse the Medicare discrimination against States like Wisconsin.

I am pleased that key provisions have been accepted that greatly improve this bill. The Senate adopted the Gregg-Schumer-McCain-Kennedy amendment, which I was proud to cosponsor and support, which will bring more competition to the prescription drug market by preventing pharmaceutical companies from blocking generic drugs from entering the market. This amendment is one of the only provisions that will help to bring cost savings to seniors.

By adopting Senator DORGAN's amendment relating to the reimportation of prescription drugs from Canada, the Senate will help seniors obtain affordable prescription drugs. This legislation helps both consumers who buy prescription drugs and businesses which sell them. I supported this provision, both in its earlier legislative form and in this amendment, because it is the right thing to do. Our seniors and other Americans in need of affordable prescription drugs deserve no less.

I also supported Senator ENZI's amendment, which passed overwhelmingly, that will make sure that community pharmacies, like the ones in my home State of Wisconsin, can still operate within this new prescription drug program. Smaller pharmacies will be protected from being shut out by larger pharmacies through this amendment, and that means helping seniors to access the prescription drugs they need in their own communities.

I also worked with Senator ALLARD on an amendment to provide regulatory relief for home health care providers that the Senate adopted. Our amendment enables home health care providers to spend more time with patients and less time on paperwork. This is particularly important at a time when some home health care providers are leaving the home health industry because of burdensome paperwork requirements.

And I am pleased that an amendment I offered to bring some clarity to the Medicare Program for our seniors was adopted. The Medicare Program is already full of bureaucratic red tape, often creating barriers for seniors looking for basic information about their health care options. This prescription drug benefit is the biggest expansion of the Medicare Program since its inception in 1965. We are adding an entire new part to the program, and we need to help guide our seniors through it.

My amendment is simple. It establishes a Medicare Beneficiary Advocate Office within the Department of Health and Human Services, with the sole function of providing clear information to all Medicare beneficiaries. The office will serve as a one-stop information source on all of Medicare for our seniors.

This new office will provide a toll-free phone number, a regularly updated website and regional publications that will give our seniors all of the information they need to make informed health care decisions.

That is the good news. But as I said earlier, I have many reservations about this bill. This is not the bill I would have proposed.

This bill does not go far enough to deliver on our promise to give seniors a meaningful prescription drug benefit. It fails to provide any assistance after a senior's prescription drug costs total $3,450, until they spend another $1,850 on prescription drugs, or $5,300 total. And it adds insult to injury by making beneficiaries continue to pay a premium even during the time they receive no benefit.

I am also troubled that this bill does not provide clear, uniform benefits and premiums for all seniors. Many aspects of the benefits provided in the bill remain uncertain, and will continue to remain uncertain after the plan goes into effect. Under this bill, the premiums are not defined. The premiums for the Medicare prescription drug plan will be dictated by the private insurers who will offer the plans. The only thing we know for sure is that the Congressional Budget Office estimates that the national average for premiums will be $35. However, those premiums may vary dramatically. Just look at Medicare HMO premiums. Medicare HMO premiums in Connecticut are $99, but in Florida they are only $16.

Who will offer the plans is also uncertain. There is no guarantee that plans will be offered in regions where there may not be enough profit. History again shows us that private companies do not always find rural and smaller urban areas profitable enough to move in. All too often, private companies that do move into less desirable Medicare markets end up deciding to leave the region, leaving Medicare beneficiaries scrambling to figure out where they will turn for coverage.

Furthermore, my understanding is that this plan only offers a guaranteed Medicare-administered plan, or ''fallback plan,'' if there are less than two private plans in a region. This means that, if only one private plan offers a prescription drug benefit in the region that includes Almena, WI, a Medicare beneficiary living in Almena may instead choose the Medicare-administered fallback plan. While on the fallback plan, my Almena constituent would become familiar with the medications that are included in their formulary and the cost of their premiums. If a second private plan subsequently decides to move into that region, my understanding is that my constituent will be dropped from the Medicare fallback plan, and forced to join one of the private plans even if those plans have higher premiums, or do not include their prescriptions in their formularies.

Further, my Almena constituent can be forced to leave the plan that he or she has come to know, if that plan leaves the region. This leads to instability and uncertainty for seniors.

Benefits are also uncertain under this proposal. Again, benefit packages will be determined by the private insurers who offer the plans. And we can assume, from experience with the Medicare+Choice Program, that the benefits will vary widely. I am concerned about what this may mean for States like my home State of Wisconsin, States that have had a difficult time attracting and keeping private Medicare plans. Some Medicare prescription drug plans may be able to offer more brand name drugs at a lower cost to beneficiaries, while others in less profitable areas may limit the amount of brand name drugs they can offer at affordable rates.

I fear that as with Medicare HMOs, Wisconsin seniors may be faced with little choice with Medicare prescription drug plans.

And I am concerned that the uncertainty in this bill regarding monthly premiums, the possible differences in benefits packages and the stability of private plans that will deliver these benefits may lead to more inequity for Wisconsin seniors.

I was disappointed that Senator DURBIN's amendment, the MediSAVE Act, was not adopted in the Senate. Senator DURBIN's amendment, which I strongly supported, would have fixed most of the errors that exist in this bill. The MediSAVE Act would have made this benefit one that would truly help all seniors with all of their prescription drug benefit. Senator DURBIN's proposal offered a meaningful, enhanced prescription drug benefit that would have covered all seniors regardless of whether their prescription drug costs are high, low, or somewhere in between.

The MediSAVE Act not only put forth cost controls so that taxpayers as well as seniors could save money, but it also would have given seniors certainty. Seniors would have known exactly what their premiums and benefits were and would have the certainty of knowing that a Medicare-administered prescription drug benefit would be available to them, no matter what private plans were offered to them. Most importantly, the MediSAVE Act provided the certainty that a senior would have assistance with their prescription drug costs year-round and would never be caught in the so-called ''donut hole'' of coverage that this bill provides.

I am voting for this bill because something, some help for our seniors with their pressing prescription drug costs, is better than nothing. I will support this legislation with the intention of working with my colleagues over the next 2 years to improve this bill and finally deliver on our promise to give seniors a meaningful prescription drug benefit under Medicare.

Mr. JEFFORDS. Mr. President, this bill is a landmark piece of legislation the most significant modernization of the Medicare Program since its inception in 1965. Its passage by the Senate is a major accomplishment on the path toward enacting a prescription drug benefit for our Nation's seniors. It is the result of years of bipartisan, I might even say tripartisan, effort and it puts in place many long-sought changes. It has many significant features for the citizens of my home State of Vermont. It provides a sustainable, universal, and comprehensive prescription drug benefit. It guarantees access to traditional Medicare for all beneficiaries. It allows Medicare beneficiaries to participate, if they choose, in new systems of care that better reflect today's dynamic health care environment. The bill recognizes the high cost of providing quality care in rural settings and closes the reimbursement

gap between rural providers and their urban counterparts. Finally, it contains a provision that will allow us to better understand how to provide quality health care—not care driven by using more and more resources, but instead one based on ensuring quality patient outcomes.

Over the past 2 weeks, I have applauded the work of my colleagues who have labored over this bill. Today, I have the pleasure of congratulating them on their success and thanking them for their efforts.

I have worked for more than 3 years with my good friends, Chairman GRASSLEY and Senators SNOWE, BREAUX, and HATCH. In many meetings over many months, we delved into the details of what came to be called the Tripartisan Bill. This has been one of the finest experiences of my many years in Congress. I am very proud to have been a part of that group and that our efforts led the way to our success today.

I especially want to salute the efforts of Senator BAUCUS and Senator KENNEDY without whose hard work and commitment to working through an agreement we would not have accomplished this remarkable victory, and they deserve our accolades.

A bill such as this is the result of great effort on the part of many different people who are not elected to this body, but upon whom we all rely. I would like to recognize the staff members who have worked so hard on this bill and deserve much of the credit for its successful passage.

On Senator GRASSLEY's staff: Ted Tottman, Linda Fishman, Colin Roskey, Mark Hayes, Jennifer Bell, and Leah Kegler, and on Senator BAUCUS' staff Jeff Forbes, Liz Fowler, Jon Blum, Pat Bousliman, Kate Kirschgraber, and Andrea Cohen deserve considerable recognition for their tireless efforts. Catherine Finley, Tom Geier, and Carolyn Holmes from my friend Senator SNOWE's staff; Patricia DeLoatche and Trecia Knight of Senator HATCH's office; and most especially Senator BREAUX's legislative director Sarah Walters deserve enormous credit for this bill. Finally, we would not be claiming a victory today if it were not for the contributions of Senator KENNEDY's staff, especially, David Nexon and Michael Meyers.

On my own staff, I particularly want to recognize the contributions of Paul Harrington during the last Congress, and most especially the work of Sean Donohue who took up that effort on the tripartisan bill and who has continued to see it through to today's success, with the recent assistance of Daniel Crimmins, our Robert Wood Johnson Health Policy Fellow. Each and all have worked tirelessly to gather the input, analyze the issues, and build a consensus toward achieving this final product.

Mr. LEVIN. Mr. President, I support making a prescription drug benefit available to seniors. Most Members of the Senate do. However, there are honest disagreements about how to get it done and whether the bill before us will strengthen or weaken Medicare.

My principles are simple. The benefit should be voluntary, guaranteed, universal, and affordable.

Perhaps my greatest concern with the bill before us is the effect its passage is likely to have on retirees who currently have prescription drug coverage provided by their former employers. Many retirees currently enjoy good prescription drug coverage from their former employer. However, the Congressional Budget Office has indicated that if we adopt the legislation before us approximately 37 percent of retirees who are currently receiving prescription drug coverage from their former employers will lose that coverage. Specifically, on June 12, the Director of the Congressional Budget Office, CBO, Mr. Douglas Holtz-Eakin, who previously served for 18 months as chief economist for President Bush's Council of Economic Advisers, testified at a Finance Committee markup that 37 percent of retirees would be dropped from their former employers coverage. At that same markup, the Administrator of HHS' Center of Medicare and Medicaid Services, CMS, Mr. Tom Scully, stated that for current retirees ''who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped.'' During the debate so far, amendments to strengthen incentives for employers to maintain their prescription drug coverage for their retirees have failed.

Also very troubling is what I call the yo-yo effect. To participate in the proposed plan, a senior in any service area where two or more private plans are offered, no matter what the premium, would only have the option of purchasing private insurance. The reason is that only if there are not two private plans offered in the region is the so-called Medicare fallback plan available. So let's assume that there are two plans offered in 2006 in a particular service area and a senior opts in. Assume further that in 2008, one of the two insurance companies pulls out of the service area and the so-called Medicare fallback plan is then available. So the senior opts for the Medicare fallback plan. However, if two private plans become available a later time, say 2009, the Medicare fallback plan is no longer available to the senior and she would then be required to again enroll in one of the private plans to retain coverage. This yo-yo effect could be repeated forcing seniors to deal again and again with different programs with different costs and different benefits and lots of paperwork. This is totally unacceptable. Seniors want stability and continuity in their Medicare Program. They want a program on which they can trust and rely.

In addition, the legislation we are considering has a large gap in the prescription drug coverage. Once a senior's total drug spending reaches $4,500 for the year, she will have to pay 100 percent of the cost of their prescriptions until her total drug spending reaches $5,800. This has come to be called the donut hole. This coverage gap will leave many seniors to pay the full cost of prescriptions at a time when they most need assistance. I know of no other insurance program that is so unfairly structured in that way. There is a gaping hole in coverage but no gap in the requirement to pay premiums. That obligation continues even during the period that benefits are halted.

The bill before the Senate also has an unspecified premium that could fluctuate from service area to service area as well as from year to year. Premium amounts are left up to the insurance companies. I believe there should be a cap on those premiums. The effort to adopt one failed.

Adding a prescription drug benefit to Medicare is one of the most important things Congress can do this or any other year. We spend more on prescription drugs than we do on hospital costs. Members of Congress have been promising for years that we would pass a Medicare prescription drug benefit for seniors. The only way to assure that the benefit will be available reliably and without complications to our seniors is to make it a guaranteed part of Medicare. The bill before us falls short of that. We should at least do no harm. When CBO estimated 37 percent of seniors currently receiving a prescription drug benefit from their former employer are going to lose the benefit because of this legislation, that is real harm.

I hope the major flaws of this bill are somehow corrected in conference so I can vote for a conference report. But I cannot vote for the version before us.

Ms. COLLINS. Mr. President, I was pleased to join my colleagues, Senators BOXER, COLEMAN, LANDRIEU, KOHL & MURRAY in offering an amendment to authorize a Medicare demonstration project on pancreatic islet cell transplantation to help advance this tremendously important research that holds the promise of a cure for more than 1 million Americans with Type 1 or juvenile diabetes.

As the founder and cochair of the Senate Diabetes Caucus, I have learned a great deal about this serious disease and the difficulties and heartbreak that it causes for so many Americans and their families as they await a cure. Earlier this week, I had the privilege of chairing a hearing featuring young delegates from the Juvenile Diabetes Research Foundation's Children's Congress who had traveled to Washington from every State in the country to tell Congress what it is like to have diabetes, just how serious it is, and how important it is that we find a cure.

Diabetes is a devastating, lifelong condition that affects people of every age, race, and nationality. It is the

leading cause of kidney failure, blindness in adults, and amputations not related to injury. Moreover, a study released by the American Diabetes Association earlier this year estimates that diabetes cost the Nation $132 billion last year and that health spending for people with diabetes is almost double what it would be if they did not have diabetes.

The burden of diabetes is particularly heavy for people with juvenile diabetes. Juvenile diabetes is the second most common chronic disease affecting children. Moreover, it is one that they never outgrow.

In individuals with juvenile diabetes, the body's immune system attacks the pancreas and destroys the islet cells that produce insulin. While the discovery of insulin was a landmark breakthrough in the treatment of people with diabetes, it is not a cure, and people with juvenile diabetes face the constant threat of developing life-threatening complications as well as a drastic reduction in their quality of life.

Thankfully, there is good news for people with diabetes. We have seen some tremendous breakthroughs in diabetes research in recent years, and I am convinced that diabetes is a disease that can be cured and will be cured.

I am encouraged by the development of the Edmonton Protocol, an experimental treatment developed at the University of Alberta involving the transplantation of insulin-producing pancreatic islet cells, which has been hailed as the most important advance in diabetes research since the discovery of insulin in 1921. Of the 257 patients who have been treated using variations of the Edmonton Protocol, all have seen a reversal of their life-disabling hypoglycemia, and 80 percent have maintained normal glucose levels without insulin shots for more than 1 year. Amazingly, many of the transplant recipients have even reported a reversal of some of their complications, such as improved vision and less pain from neuropathy.

Earlier this year, I joined with my colleague from Washington, Senator PATTY MURRAY, as well as my colleague and cochair of the Senate Diabetes Caucus, Senator JOHN BREAUX, in introducing the Pancreatic Islet Cell Transplantation Act of 2003, which will help to advance this significant research that holds the promise of a cure for the more than 1 million Americans with juvenile diabetes. The amendment we are introducing today is based on one of the provisions of that bill, which currently has 43 Senate cosponsors.

Diabetes is the most common cause of kidney failure, accounting for 40 percent of new cases, and a significant percentage of individuals with Type 1 diabetes will experience kidney failure and become Medicare-eligible before they are 65. Medicare currently covers both kidney transplants and simultaneous pancreas-kidney transplants for these individuals. To help Medicare decide whether it should cover pancreatic islet cell transplants, the amendment authorizes a 5-year demonstration project to test the efficacy of pancreatic islet cell transplantation for individuals with Type 1 diabetes who are eligible for Medicare because they have end-stage renal disease, ESRD.

The cost of this demonstration would not be high. The Health Strategies Consultancy LLC, a highly regarded independent health policy firm, estimates that the net Federal cost of the proposal would be about $6.2 million in 2004 and about $84 million over 10 years.

The cost of the demonstration project is low because the number of islet cell transplants that could be performed is limited. Islet cells are extracted from a donated pancreas, and the number of pancreas donors is extremely small when compared to the number of Medicare beneficiaries who could benefit from islet cell transplants. In 2002, there were 1,875 pancreas donations, but there were over 27,000 Medicare beneficiaries who have diabetes as the primary cause of their end-stage renal disease and who might potentially benefit from islet cell transplants.

The Health Strategies' cost estimate does not include the financial benefits that would accrue to Medicare for the reduced medical care costs that would occur for beneficiaries who receive islet cell transplants and, as a result, suffer fewer diabetes-related complications such as kidney failure, heart disease, blindness and amputation. Since diabetes currently accounts for one out of every four Medicare dollars, I believe that this amendment actually holds much promise for reducing Medicare spending in the future.

I understand this demonstration project has been included in the Medicare prescription drug legislation that is being considered by the House. I hope that the Senate demonstrates similar wisdom, and I urge all of my colleagues to support it.

Mr. KOHL. Mr. President, I rise to oppose S. 1, the Prescription Drug and Medicare Improvement Act. This bill is good for drug companies, insurance companies, and people who make TV ads for politicians—but it is not good for Wisconsin seniors.

I know that many of my colleagues will vote for this legislation and that it will pass the Senate. I know that many of my colleagues believe that this is a first step, if an imperfect one. I would like to agree with them. I would like to vote for a bipartisan compromise that delivers even a part of the drug benefit our seniors rightly demand. But this is not that bill. This is, instead, an empty promise of straightforward help for seniors struggling with crippling drug costs. When they figure out the details—when they see the costs—when they understand the limited benefit provided—when they work through the complicated formulas determining whether they ought to sign up—when they see the drug industry continue to raise their prices and reap record profits—they will—rightly, rightly—revolt.

I warn my colleagues, this is no bird in the hand—it is a vulture. And I cannot support it.

I cannot support a so-called benefit that asks many seniors, for months at a time, to pay premiums but receive absolutely no help with their drug costs. I cannot support a ''benefit'' that could cause up to 37 percent of retirees to lose their retiree health plans, leaving their former employees worse off than before we passed this bill. And I cannot support a ''benefit'' which is denied to low-income seniors eligible for both Medicaid and Medicare. A ''benefit'' of no benefit for seniors above average drug costs, for seniors with decent retiree plans, for seniors who are poor.

I also cannot support a plan that neither I nor anyone in this body can explain because its details depend on the vagaries of a private market that doesn't exist yet. Under this system, seniors could be forced into a different plan, pay a different premium, and have different medicines covered every year. Insurance companies can come in and out, leaving seniors lost and confused in a maze of paperwork and choices every year. And we know that for those insurance companies that do participate, premiums are sure to increase because there is no limitation on premiums in this law.

I also cannot support a plan that relies so heavily on the private sector to offer something they have never been willing to offer before. Drug-only plans are virtually nonexistent in today's marketplace. And the Medicare+Choice experiment, which also uses private insurance companies, has not worked in Wisconsin and in many other States. I cannot support a plan that has to pay insurance companies huge subsidies in order to offer a drug benefit. Not only is there no guarantee that they will participate; but precious Medicare dollars that could be used to pay directly for medicines are wasted, funneled to a drug industry that, last I checked, was not in need of a Federal handout. Even worse, this plan does not take advantage of the potential for controlling drug costs by utilizing the purchasing power of the millions of Medicare beneficiaries.

I do not want to point out that aside from the Medicare drug benefit, there are several provisions that I strongly in this bill. I am very pleased that the bill includes long-needed reforms that will finally take a strong step toward fixing the distorted Medicare system we have today—a system that penalizes Wisconsin health care providers by paying them less than other States, and a system that penalizes Wisconsin seniors by offering them fewer benefits than seniors in other States enjoy. Not only is this unfair for people in the Medicare system; it also increases costs for Wisconsin businesses, employees, and families, who pay higher costs

to make up the Medicare shortfall. The bill before us changes many of Medicare's payment systems, especially for rural areas, and goes a long way toward making Medicare fair for seniors and providers, no matter where they live.

I am also pleased that the bill includes provisions to make generic drugs more available to all Americans. It will close loopholes in our current law that keep generics off the market and keep drug prices too high for too long. The CBO estimates that this provision will save Americans $60 billion over 10 years.

I hope, but don't expect, that these two important provisions will survive the upcoming conference with the House of Representatives. And while I continue to hope that the conference will come back with a better Medicare drug benefit, I regret that it is unlikely to be the case. The House bill is in many ways even worse than the Senate bill before us.

Mr. President, I regret that none of the amendments that I supported during this debate prevailed. These amendments would have greatly improved this bill and provided a real prescription drug benefit to seniors—a benefit we could all have been proud of. Instead, this bill is an empty promise to seniors and the disabled on Medicare. This is not the kind of plan they have been asking for or have a right to expect. We could and should have done better. But at minimum, we could and should be able to hold our work here to the standard set in the Hippocratic Oath: do no harm. And we have failed.

I yield the floor.

Ms. COLLINS. Mr. President, I want to thank the chairman of the Finance Committee for including provisions in S. 1 that will provide a measure of relief to rural health care providers, and in particular to home health agencies serving patients in rural areas. I am concerned, however, that the underlying bill does not go quite far enough and have filed an amendment with Senator BOND to increase the rural add-on payment for home health agencies to 10 percent. This was the amount of the payment prior to its expiration on April 1, and I believe it is the amount that is necessary to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

Home health has become an increasingly important part of our health care system. The kinds of highly skilled—and often technically complex—services that our Nation's home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors. Because of the longer travel times, rural caregivers are unable to make as many visits in a day as their urban counterparts. Saundra Scott-Adams, the executive director of the Visiting Nurses of Aroostook in Aroostook County, ME, where I am from, tells me her agency covers 6,600 square miles with a population of only 72,000. Her costs are understandably much higher than the average agency due to the long distances her staff must drive to see clients. And, her staff is not able to see as many patients.

Agencies in rural areas are also frequently smaller than their urban counterparts, which means that their relative costs are higher due to smaller scale operations. Smaller agencies with fewer patients and fewer visits mean that fixed costs, particularly those associated with meeting regulatory requirements, are spread over a smaller number of patients and visits, increasing overall per-patient and per-visit costs.

Moreover, in many rural areas, home health agencies are the primary caregivers for homebound beneficiaries with limited access to transportation. These rural patients often require more time and care than their urban counterparts, and are understandably more expensive for agencies to serve. If the rural add-on payment is not reinstated, agencies may be forced to make decisions not to accept rural patients with greater care needs, and access will suffer further.

The loss of the rural add-on has already caused many agencies to reduce their service areas. Some are eliminating services altogether in remote areas. There are some counties in Montana, for example, that have no home health services. And agencies in my home State of Maine have had to eliminate delivery of services to some of our outlying islands.

If the 10 percent rural add-on payment is not restored, it will only put more pressure on rural home health agencies that are already operating on very narrow margins and could force more of these agencies to close. Many home health agencies operating in rural areas are the only home health providers in a vast geographic area. If any of these agencies are forced to close, the Medicare patients in that region will lose complete access to home care.

There is strong support in the Senate for restoring the rural add-on. Earlier this month, 55 Senators joined me in sending a letter to the chair and ranking member of the senate Finance Committee urging that they extend the 10 per cent rural add-on for home health agencies, and I ask unanimous consent that this letter be printed in the RECORD.

The chairman of the Finance Committee and his staff have been working with us to try to accommodate my amendment, and I am very appreciative of their efforts. I am hopeful that we will be able to work this out so that we will be able to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, June 5, 2003.

Hon. CHARLES E. GRASSLEY, *Chairman,*
Hon. MAX BAUCUS, *Ranking Member,*
Senate Committee on Finance, Dirksen Senate Office Building, Washington, DC.

DEAR SENATORS GRASSLEY AND BAUCUS: Home health has become an increasingly important part of our health care system. The kinds of highly skilled and often technically complex services that our nation's home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

By the late 1990s, home health was the fastest growing component of Medicare spending. The rapid growth in home health spending understandably prompted the Congress and the Administration—as part of the Balanced Budget Act of 1997—to initiate changes that were intended to slow this growth in spending and make the program more cost-effective and efficient. These measures however, produced cuts in home health spending far beyond what Congress intended. Home health spending dropped to $10 billion in FY 2002, nearly half the 1997 amount, and it is clear that the savings goals set for home health in the Balanced Budget Act have not only been met, but far surpassed.

According to the Congressional Budget Office (CBO), the post-Balanced Budget Act reductions in home health spending totaled more than $72 billion between fiscal years 1998 and 2002. This is over four times the $16 billion that the CBO originally estimated for that time period and is a clear indication that the Medicare home health cutbacks have been far deeper than Congress intended.

As a consequence of these cutbacks, over 3,400 home health agencies nationwide have either closed or stopped serving Medicare beneficiaries. Moreover, the number of Medicare patients receiving home health care nationwide has dropped by 1.3 million—more than one-third. Which points to the central and most critical issue—cuts of this magnitude simply cannot be sustained without ultimately affecting patient care.

On October 1, 2002, home health agencies received an additional across-the-board cut in Medicare home health payments, and the Centers for Medicare & Medicaid Services has dramatically reduced projections for home health spending under the Medicare program over the next ten years. We are concerned that any further cuts in payments for home health services simply cannot be sustained without affecting patient care, particularly for those Medicare beneficiaries with complex care requirements.

As you begin consideration of a Medicare modernization package, we urge that you avoid any further cuts in payments for home health services and preserve the full market basket update for payments for home health services for 2004. In addition, we urge that you extend the 10 percent add-on payment for home health services in rural areas that expired on April 1, 2003. Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and

other factors. Extension of this add-on payment will therefore help to ensure that Medicare patients in rural areas continue to have access to the home health services they need.

Thank you for your consideration, and we look forward to working with you to ensure that elderly and disabled Americans continue to have access to quality home health services.

Sincerely,

Susan M. Collins; Christopher S. Bond; Wayne Allard; Gordon Smith; Robert F. Bennett; Richard Lugar; Jack Reed; Russell D. Feingold; Patty Murray; John W. Warner; James Talent; Carl Levin.

Charles Schumer; Chuck Hagel; Barbara Mikulski; Jon Corzine; Tim Johnson; Patrick Leahy; Herb Kohl; Mary Landrieu; Evan Bayh; Dianne Feinstein; Hillary Rodham Clinton; Maria Cantwell; Frank Lautenberg; Ron Wyden; John Kerry; Ben Nelson; Debbie Stabenow; Mark Dayton; Ben Nighthorse Campbell; Mike DeWine.

Arlen Specter; George Voinovich; James Jeffords; Bill Nelson; Saxby Chambliss; Conrad Burns; Christopher Dodd; Joseph Lieberman; Blanche L. Lincoln; Larry Craig; Paul Sarbanes; Lincoln Chafee; Mike Crapo; Richard Durbin; Barbara Boxer.

Tom Harkin; Pat Roberts; Jim Bunning; Ted Kennedy; Sam Brownback; Byron Dorgan; Thad Cochran; and Richard Shelby.

Mr. DODD. Mr. President, I rise today to speak in support of S. 1, the Prescription Drug and Medicare Improvement Act of 2003. However, I do so with great trepidation. While I intend to vote for the bill that is presently before the Senate, I believe that drastic changes are still necessary to make the benefit created by this legislation one that meets the needs of our senior citizens.

I am also deeply concerned that Members on the other side of the aisle—as well as those in the House of Representatives, and the administration—will attempt to move this bill in a destructive direction during conference. Let me reiterate what I said in an earlier statement on this issue: we must not approve any Medicare reform measure that would force seniors to join private plans in order to receive a more generous prescription drug benefit. Such a measure would signal an end to the Medicare Program as we know it and should be rejected out of hand. I urge my colleagues to protect the Medicare that our seniors have come to rely on, and I urge the President not to sign any bill that privatizes Medicare. If such changes are made, I will not hesitate to oppose the conference report.

Given these concerns, it is reasonable to ask why I am supporting this bill. The answer is quite simple—seniors in my home State of Connecticut and across the country have been waiting far too long for a prescription drug benefit under Medicare. And it is time that we in Congress heard them.

Over the past month I had the opportunity to convene a series of forums on senior health care in Connecticut in an attempt to frame the scope of this debate. At these forums I heard from my constituents on many matters regarding their health care. But the present lack of coverage for prescription drugs under the Medicare program was by far the issue raised most often.

At these forums I heard from seniors who literally could not afford to fill prescriptions called for by their doctors. I heard from elderly Medicare beneficiaries forced to choose between purchasing groceries or filling their prescriptions. I heard from seniors who were forced to skip dosages of their medicines in an attempt to stretch their limited supplies of needed medicines. I heard from Medicare beneficiaries requiring more than 10 prescribed medicines a day unable to afford even half of these prescriptions. Clearly, what I heard from hundreds of Connecticut's more than 500,000 Medicare beneficiaries is their grave concern over the present lack of a prescription drug benefit under the Medicare Program.

I believe that the legislation about to be approved by this body offers an answer to those concerns. It is not the most complete answer, but it is a start—based on which we can improve in the future. It is a start because it will make so many seniors better off than they are today. And that should be our ultimate goal as legislators—to make people's lives better. Often this must be done incrementally, in steps. This bill is a positive first step.

What do I mean when I say that it will make people better off? In Connecticut, one-third of all Medicare beneficiaries have incomes below 160 percent of poverty. For many of these seniors, drug costs can be crippling. They are forced to choose between putting food on the table, and buying the medicines that they need to live healthy lives. With the passage of this bill, these seniors will no longer have to make this choice. The new Medicare prescription drug benefit will cover most, if not all, of their drug costs. I congratulate Senator GRASSLEY and Senator BAUCUS, and other members of the Senate Finance Committee for including in this bill such a generous benefit for those low-income seniors.

This legislation is not as clear cut for those seniors who have incomes above 160 percent of poverty. However, I believe that the majority will be helped by passage of this bill. The break even for this benefit—the point where an individual is better off with the benefit rather than just paying for all prescription drugs our of their own pocket—is about $1,100 in total annual drug costs. The average Medicare beneficiary spends approximately $2,300 on prescription medicines today. That number will undoubtedly be higher when this new benefit goes into effect in 2006. With the benefit created by this bill, that average beneficiary will realize nearly $600 in savings. The savings will be even greater for the 11 percent of beneficiaries who spend more than $5,000 per year on prescription drugs. These are the seniors facing the most sever health problems, and most in need of financial assistance. That is what this bill provides—even if it is not to the extent that many of us would have liked.

I am voting for this bill because so many seniors in Connecticut and throughout the country stand to benefit. However, no bill is perfect and S. 1 clearly still leaves much room for improvement even as it moves toward final Senate passage. I am particularly disheartened that, despite numerous attempts over the past 2 weeks, we have failed to address concerns over the present bill's lack of adequate provisions to ensure that those companies presently providing their retirees with prescription drug coverage receive adequate Federal support for their laudable efforts. While the creation of a prescription drug benefit under the Medicare program is laudable, it should not come at the price of displacing the employer-based benefits that so many seniors have come to rely on.

Additionally, I remain concerned that the gap in coverage in the present bill, the so-called donut hole, will leave many Medicare beneficiaries facing high prescription drug costs with no assistance at the very time when it is most needed. Over the past 2 weeks, I have both offered and supported amendments designed to provide assistance to those with prescription drug costs within the hole, especially those with lower incomes who can least afford any gap in coverage, that have failed to win support by the Senate. Failure to close this gap, in my view, constitutes a glaring failure, one that I hope can be reversed as this bill moves into conference.

I also am concerned that S. 1 fails to adequately protect Medicare beneficiaries form the very understandable confusion and uncertainty that may surround them just as they begin to navigate the intricacies of a brand-new program. Specifically, if enacted the underlying bill will require Medicare beneficiaries choosing a prescription drug plan to stay with that plan for a minimum of 1 year. With the enactment of such broad and weeping changes to the Medicare program, I am fearful that many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular needs. For this reason, I offered an amendment to S. 1 that would have simply granted Medicare beneficiaries navigating this new benefit for the very first time the ability to switch plans as they seek to determine which plan fits their particular health care needs in the first 2 years of the bill's benefit. Unfortunately, this amendment was not agreed to and I remain concerned that without its protections, senior Medicare beneficiaries will be unfairly locked into plans that do not meet their needs.

Mr. President, I am pleased that S. 1 represents a significant departure from

previous plans supported by the administration that would have required Medicare beneficiaries to leave the traditional fee-for-service Medicare Program in order to receive coverage for their prescribed medicines. Such a move would be unconscionable as 89 percent of all Medicare beneficiaries today are in the traditional program. To force these beneficiaries to leave their present system of coverage, and most likely the doctor that they have come to know and trust, would not only create great disruption, it would also for the first time since the program's inception create a tiered benefit system under Medicare that would more greatly reward those who choose to join a private preferred provider organization, PPO, or health maintenance organization, HMO.

And while I am pleased that the bill before us soundly rejects a tiered benefit system, I am deeply concerned that the plan presently taking shape in the House of Representatives appears to rely on such a flawed plan. As I said earlier, such a measure should be soundly rejected.

So it is with great caution that we come to the final moments of debate on this important issue. Medicare's nearly 41 million beneficiaries clearly need assistance in affording their needed medicines. The result of our efforts over the past 2 weeks, and more important, the result of the coming conference committee on this legislation will greatly determine to what extent we assist our Nation's Medicare beneficiaries to afford their needed medicines.

Clearly, a great opportunity is presently before us. As the underlying bill moves to conference committee. I look forward to working with my colleagues to ensure that we seize this opportunity by strengthening the underlying bill. With passage of the bill presently before us, we now face a choice. We can insist on the good start that we have made here with passage of S. 1, and work to strengthen its provisions. Or, conversely, we can accede to the House legislation that in my view unfairly jeopardizes the traditional Medicare Program by tilting the system in favor of risky privatization schemes and against seniors.

I ask my colleagues to join with me in working to ensure that any Medicare prescription drug legislation passed by this Congress is at least as strong as the bill we are about to vote on. A tilt toward the House-drafted language would signify not a strengthening of Medicare, but rather a weakening of this vital program's foundation and must be avoided at all costs.

Nearly 38 years ago on July 9, 1965, this body passed the legislation creating the Federal Medicare Program sending it to a conference committee with the House. On that day, President Lyndon Baines Johnson remarked, ''This is a great day for older Americans. And it is a great day for America. For we have proved, once again, that the vitality of our democracy can shape the oldest of our values to the needs and obligations of today.'' Nearly four decades later, we are on the cusp of a similar challenge. Let us move Medicare toward the future without threatening its proven ability to provide for the health and well being of this Nation's senior citizens.

Mr. COLEMAN. Mr. President, I am proud to mark this extraordinary day by coming to the floor of the Senate to celebrate the imminent passage of a prescription drug benefit for Medicare. This is a triumph not for a party or a President, but for America's seniors and their families. This is an incredibly hopeful day for all Americans who long for a national government that can get things done for people.

Thirty-eight years ago Congress voted to create a health care program that would be the primary source of health insurance for this Nation's seniors. Most people would agree that this program has served us well for almost four decades. However, the practice of medicine has changed. Drug therapies, medical devices, and human genome research all hold great hope for breaking through physical limitations that hinder many seniors' ability to enjoy the later years of life.

The question we now ask is what level of care are we going to provide our seniors and is the current system equipped to provide the type of care our seniors need and deserve.

The benefits provided under Medicare, considered generous at its inception in 1965, pale in comparison to those enjoyed by Federal employees and most workers in the private sector today. A recent report submitted by the Joint Economic Committee found that Medicare has the least generous benefit package among leading forms of insurance. Medicare covers 56 percent of total health care expenses, while typical employment-based health insurance covers 70 percent.

Seniors need prescription drug coverage. Seniors need better access to preventative care and disease management. Seniors need more choices in their health care options than they have today. Without updating, it may take years to add this kind of care to the current program—after all, it has taken over 30 years to add a prescription drug benefit.

The Prescription Drug and Medicare Improvement bill is a step toward meeting the needs of this Nation's seniors.

This bill provides a solid drug benefit that will provide assistance to every senior struggling to pay for prescription drugs as well as the security of knowing they are covered for unforeseen drug expenses.

Under this plan, the average senior's annual drug costs will be reduced by 53 percent each year. That amounts to $1,677 each year back in the pocket of our seniors. And seniors with the greatest needs will receive additional assistance through increased cost-sharing, and reduced or waived monthly premiums and deductible.

Equally important, this plan provides seniors with the security of knowing that they are covered in the event something happens and they find themselves facing exorbitant drug costs. At $3,700 in out of pocket drug costs, stop-loss coverage kicks in and the senior is only responsible for 10 percent of costs beyond this amount.

This bill is also about expanding options for this generation and future generations of seniors. The incremental improvements to the Medicare program have largely been the result of legislative action over the last 40 years. The legislative process, however, is not a quick process, and it is simply not possible to keep the program current in the first parcel environment we currently live.

The Medicare Advantage program included in this bill offers seniors the choice of receiving their health care benefits in a Preferred Provider Organization, PPO, the same type of health plan enjoyed by many families.

Under this health care option—not mandate—seniors will have increased access to the latest advances in care such as desire management and better preventive screenings. Additionally, seniors who chose this option will also have a lower deductible for inpatient and hospital care than those in traditional Medicare.

This bill lays the foundation for a Medicare program that is better able to respond to an evolving health care system by harnessing the efficiencies of the health care market, while preserving traditional Medicare for those seniors who are satisfied with their current coverage.

This bill is about expanding options for seniors so our parents and grandparents have access to the type of care best suited for them.

Is this bill everything everyone wants? Of course not. Are there decisions still to be made as it is implemented and we see how it actually works in the marketplace? Certainly. But this bill says we are not going to let the lack of perfection stop us from doing real good for people as soon and as effectively as we practically can.

I would be remiss if I didn't express my appreciation to Senators GRASSLEY and BAUCUS for their leadership in including many provisions in this bill to strengthen rural health care.

The availability of health care in rural areas in Minnesota is absolutely critical to the stability and viability of many communities.

The provisions in this bill to improve payments to hospitals in rural areas and reduce the geographic disparity in physician payments are critical to ensuring that these hospitals that threat not only seniors, but entire communities continued to receive care.

I am pleased that we did not allow perfect to be the enemy of good as we considered this package.

This is a substantial and dependable benefit for America's seniors. Again,

it's not everything everyone wants. There are still decisions to be made as it is implemented and we monitor how it works in the marketplace. But today we are delivering on a promise to provide quality care to our seniors.

I am hopeful that with bipartisan support this landmark legislation will pass the Senate and the House of Representatives by the July 4th holiday. When it does, there may not be any fireworks and parades but millions of seniors will be able to declare their independence from worrying about getting the prescription drugs they need to live a quality life.

Mr. BIDEN. Mr. President, after many years of preparation and deliberation, and following weeks of debate and discussion on the floor this year and last, we in the Senate are about to vote on a bill providing some prescription drug benefits for Medicare beneficiaries that is widely expected to pass.

Seniors have been demanding prescription drug coverage for many years now. They need it and they deserve it, and I believe what we should be passing here today is a bill that will bring the American people the type of prescription drug benefit they have been seeking—one that is easy to understand and use, one that covers a substantial portion of all their costs, and one that is affordable.

But to the many Medicare beneficiaries who will read the details of this bill and say, ''there isn't much in here for me and it will cost me more than I am now paying for drugs,'' I would say: I hear you. This bill is not enough, not nearly enough.

I have a lot of concerns about this bill. There is no uniformity from region to region in the benefit package or beneficiary payments. Seniors in the East could be paying far higher premiums than their relatives in the Midwest.

The drug plan relies on private insurance companies to provide a type of insurance policy that they have already said they are unwilling to sell. I am skeptical that these private plans will stay, and that could mean seniors will have no stability in their coverage. The bill does allow traditional Medicare to step in and fill the gap but seniors might have to move back to a private drug plan if new ones come to the region.

There is also a gap in coverage which I think is unfair and will surprise a lot of people.

Finally, the bill falls short in its efforts to induce employers not to abandon their retiree prescription drug coverage, a situation that too many retirees have already faced in recent years.

In summary, I view this bill not as a situation where we would say that the glass is half full and half empty; to my thinking, the glass is only about one-quarter full. In 2003, prescription drugs are as important in medical care as surgery; consequently, it seems logical to me that if Medicare pays for the bulk of the cost of a heart bypass operation for all beneficiaries, it should similarly pay the bulk of the cost of the drugs used to lower the cholesterol, and which would prevent the need for the bypass operation, for all beneficiaries. This bill does not achieve that commonsense goal. Not even close.

But we need to start somewhere. This is the first step in gradually moving the health plan that covers nearly 40 million seniors and disabled individuals into the 21st century. And it is, very frankly, the best that we can expect to pass this Congress and that the President will sign.

There are some good provisions in this bill. All Medicare beneficiaries will have access to a prescription drug plan. Individuals with low incomes, below 160 percent of Federal poverty level, will have access to prescription drug coverage at very little cost. Those with very high prescription drug expenses, in the many thousands of dollars, will have stop-loss protection to help protect them against catastrophic drug costs. And no one is forced to abandon the traditional Medicare Program for their basic health care, with which they are so familiar, in order to obtain prescription drug coverage.

During the Senate deliberation on this bill, I have voted for amendments that would improve the prescription drug coverage and decrease the cost to beneficiaries. Almost all of these amendments were not adopted, mostly with the rationale that there was not enough money. I do not feel constrained by some arbitrary $400 billion cost limit on this bill. I never agreed to such a limit. In fact, my sense of values tells me that prescription drug benefits are a high priority, and I would be willing to spend more than $400 billion for a good prescription drug plan, while cutting budget items of lower priority, such as tax cuts for the very wealthy.

In the end, I decided to vote for this bill, despite its severe limitations. Given the many past years of fruitless discussions on this matter, I feel it is critical to put something into law now that can serve as a starting point for development of a true prescription drug plan. But that is not to say that I will accept any lesser of a bill, and my colleagues should not count on my continued support, if the final version of this bill that comes out of negotiations with the House of Representatives undercuts the Medicare Program or moves toward reducing protections for beneficiaries.

We also need to remember, this bill comes with a warning to all of us: the public is a lot smarter than they are sometimes given credit for, and if we do not work diligently to improve what we have begun, they will rightly take out their anger on us. We need to ensure that this bill is the first step, not the last step.

Mr. GRASSLEY. Mr. President, parliamentary inquiry. Are we now ready for third reading?

The PRESIDENT pro tempore. The question is on agreeing to the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The PRESIDENT pro tempore. The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that following passage of S. 1, the bill be held at the desk; further, when the Senate receives from the House the companion measure to S. 1 the Senate proceed to its consideration, all after the enacting clause be stricken, and the text of S. 1 as passed be inserted in lieu thereof; the bill then be read a third time and passed with the motion to reconsider laid upon the table; further, that the Senate then insist on its amendments and request a conference with the House, and the Chair be authorized to appoint conferees with a ratio of 5 to 4; finally, with that action, I ask unanimous consent that passage of S. 1 be vitiated and the bill be placed back on the calendar.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I want to take a few moments to return to the basics of what this bill is all about. Let's keep our eyes on the ball.

We are working here to make a meaningful improvement in health care for seniors. We are working to bring prescription drug coverage to Medicare beneficiaries.

Too many seniors do without drug coverage. The Congressional Budget Office reports that roughly a quarter of Medicare beneficiaries have no drug coverage. Ten million people. They have to pay all of their drug costs out of their own pockets. They pay full price.

Lack of coverage means poorer health. Seniors who get along without drug coverage get fewer of the healing benefits that prescription drugs provide. CBO reports that when seniors do not have drug coverage, they fill about a quarter fewer prescriptions, on average, than do those who have coverage.

But whether seniors have coverage or not, they still need a significant amount of prescription drugs. CBO says that in 1999, Medicare beneficiaries who had coverage filled an average of 32 prescriptions a year. Those without coverage still filled an average of 25 prescriptions a year.

These prescriptions cost seniors a good deal of money. The average Medicare beneficiary spends about $2,500 a year on prescription drugs. That's a big number—especially as the median income for all elderly households in 2001 was less than $19,000.

Those costs are rising fast. CBO projects that the average Medicare beneficiary's drug costs will rise at a

rate of more than 10 percent a year over the next decade. That is far faster than the cost of living. That means that without this legislation, seniors will need to devote larger and larger shares of their income to paying prescription drug bills.

So we are here to try to make prescription drugs more affordable for seniors. And we are here to extend coverage to the roughly 10 million seniors who have no prescription drug coverage at all.

We are here to try to end seniors' painful choice between filling prescriptions and buying food. Seniors should not have to choose among the necessities to maintain their health. We are here to do something about that today.

Let me review what this bill would do.

This bill would make available prescription drug insurance to all seniors.

This bill would ensure that 44 percent of Medicare beneficiaries—those with the lowest incomes—would have truly affordable prescription drug coverage with minimal out-of-pocket costs. For these lower-income seniors, with incomes up to 160 percent of the poverty level, copayments would never exceed 20 percent of the cost of drugs.

Let me take some examples. Let's look at what this bill would do for beneficiaries with what will likely be average drug spending of $3,155 in 2006.

For seniors with average drug expenses, even with higher incomes, this bill would save them $1,677. That is a 40 percent savings in out-of-pocket costs.

The savings would be greater for lower income seniors. For an individual making $14,000 or a couple making $19,000 a year, with average drug spending, they would save $2,842. That is a 90 percent savings in out-of-pocket costs.

For an individual making $12,000 or couple making $16,000 a year with average drug spending, they would save $2,842 in out-of-pocket costs. That would be a savings of 96 percent in out-of-pocket costs.

This bill would thus ensure that those who have been least able to receive the healing benefits of prescription drugs would now be able to do so. Millions of people would have a better quality of life. Lives would be saved.

This bill would create a strong Government fallback. Seniors would have access to at least two private plans for a prescription drug benefit, or the Government would provide a standard fallback plan. If there is not true competition, then traditional Medicare would provide a fallback.

The Department of Health and Human Services would continue to oversee these plans. The plans would operate within tightly controlled limits. This bill includes strong consumer protections.

And this bill does not tilt the playing field. This bill does not make private plans a better deal than traditional Medicare.

This bill would make a nearly $400 billion expansion of a major entitlement program. This is a historic opportunity to make a fundamental change for the better for millions of Americans.

In so doing, this bill would finally do something that the overwhelming majority of industrialized nations have already done.

This is a broad compromise. This is not a bill of the left or a bill of the right. This is a weaving together of approaches, in the finest American tradition.

This is a historic opportunity. Let us finally seize that opportunity, and improve health care for our seniors. Let us finally seize the opportunity, and bring prescription drug coverage to all.

Mr. GRASSLEY. Mr. President, we are about to take a historical vote.

Since 1965, Medicare hasn't covered prescription drugs. Now, 38 years later, we're changing that—on a strong bipartisan basis.

Because of this bill, on January 1, 2004, seniors across America will have immediate help with prescription drug costs. Moreover, on January 1, 2006, seniors will have access to affordable, comprehensive drug coverage as a permanent part of Medicare.

No longer will seniors have to make hard choices when it comes to paying for prescription drugs.

This bill also strengthens and improves Medicare, giving seniors more choices and better benefits than they have today.

At the same time, it brings long overdue Medicare equity to the people of Iowa and to other rural States.

We are on the verge of a major victory.

I urge my colleagues to support S. 1.

Mr. BAUCUS. Mr. President, we are about to vote. I want to thank all Senators for their tremendous patience. It is not an easy task. I particularly thank the chairman of the committee but also all Senators.

Second, I thank the staff who have not had any sleep in the last two or three weeks. I don't know how they are still standing. A lot of people have been working on this bill. My thanks. I know I speak for all the Senators in thanking all the staff that worked so hard to help achieve this end.

The PRESIDENT pro tempore. The bill having been read the third time, the question is, shall it pass?

Mr. HOLLINGS. Mr. President, I ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 76, nays 21, as follows:

[Rollcall Vote No. 262 Leg.]

YEAS—76

Akaka	Daschle	Lugar
Alexander	Dayton	McConnell
Allen	DeWine	Mikulski
Baucus	Dodd	Miller
Bayh	Dole	Murkowski
Bennett	Domenici	Murray
Biden	Dorgan	Nelson (FL)
Bingaman	Durbin	Nelson (NE)
Bond	Enzi	Pryor
Boxer	Feingold	Reid
Breaux	Feinstein	Roberts
Brownback	Fitzgerald	Schumer
Bunning	Frist	Sessions
Burns	Grassley	Shelby
Campbell	Hagel	Smith
Cantwell	Hatch	Snowe
Carper	Hutchison	Specter
Chafee	Inouye	Stabenow
Chambliss	Jeffords	Stevens
Cochran	Johnson	Talent
Coleman	Kennedy	Thomas
Collins	Kyl	Voinovich
Conrad	Landrieu	Warner
Corzine	Lautenberg	Wyden
Craig	Leahy	
Crapo	Lincoln	

NAYS—21

Allard	Graham (SC)	McCain
Byrd	Gregg	Nickles
Clinton	Harkin	Reed
Cornyn	Hollings	Rockefeller
Edwards	Kohl	Santorum
Ensign	Levin	Sarbanes
Graham (FL)	Lott	Sununu

NOT VOTING—3

Inhofe	Kerry	Lieberman

The bill (S. 1), as amended, was passed.

(The bill will be printed in a future edition of the RECORD.)

The PRESIDENT pro tempore. Without objection, the title amendment is agreed to.

The title was amended so as to read: ''A bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes.''.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

The PRESIDENT pro tempore. The Chair, in my capacity as a Senator from the State of Alaska, moves to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. INHOFE. Mr. President, because of urgent business back in my State of Oklahoma, I will be unable to be in attendance to vote on S. 1. It makes no difference, however, because I would have voted against it.

Last week, I addressed this Chamber regarding S. 1, the Prescription Drug and Medicare Improvement Act. At that time, I said I could not support the legislation in its current form and expressed my hope that it could be improved on the floor. Unfortunately, that has not occurred. I am restating my opposition to this legislation.

This is simply another Federal entitlement program designed to balloon past expected costs of $400 billion. For

example, in the past, Medicare expenses have soared nearly five times the projected costs. I remember that well because I remember in 1965 when it was passed. This trend will only escalate if we continue to add unfunded obligations without ensuring the long-term solvency of the entire program.

We must examine the necessity of such obligations prior to placing the burden on the backs of the future taxpayers. And is a full prescription drug benefit necessary? Currently, 76 percent of seniors already have some form of prescription drug coverage. A recent Zogby poll found that three-fourths of seniors thought the coverage offered under this plan would be no better than what they currently have. In fact, less than one-half would even purchase the option if given the choice. However, with the passage of S. 1, those individuals may not be given that choice. CBO estimates that one-third of Medicare beneficiaries with employer-sponsored coverage will lose those benefits once the bill takes effect. Seniors who currently have private coverage that they like will be forced to buy the Government-sponsored benefit simply because it is the only thing that will be available.

There is something wrong with that picture. The Government should not be replacing coverage that already exists. However, this legislation opens the door for continued Government intervention. With the inclusion of the fallback provision, this benefit has the potential to become fully federalized if private plans do not surface. Once again, we are placing more and more expense at the door of the taxpayers, our children, and our grandchildren.

I am concerned about the effect this bill could have on the future of the entire Medicare Program. I have worked with my colleagues to support improvements to this legislation. I and many of my colleagues have signed letters to both Senator FRIST and President Bush outlining the principles that need to be included in the final version of this bill. I also cosponsored an amendment with Senators ENSIGN, HAGEL, and LOTT to provide a more reasonable prescription drug benefit that does not create a massive entitlement program. I believe the House of Representatives is on the right track with this issue.

I am hopeful that with the passage of S. 1, the conferees will work to see that the final legislation adheres to the principles stated in the letters to President Bush and Senator FRIST and the proposal supported by the House. At that time, I will look forward to supporting this legislation.

The PRESIDENT pro tempore. The majority leader.

Mr. FRIST. Mr. President, for years Congress has debated providing prescription drug coverage to seniors and how to strengthen and improve the Medicare Program. Tonight we have acted. Tonight America is one step closer to being a more caring society for millions of seniors and individuals with disabilities. Tonight seniors and individuals with disabilities, through this bill, will get relief from high prescription drug costs and outdated, often inadequate medical care. Tonight we are one step closer to providing real health care security to seniors all across the Nation.

We stand on the shoulders of many in this body and in the House of Representatives who have labored mightily to improve the Medicare Program. We have reached this point of success because of the commitment of the leadership in the House as well as the Senate. Above all, we are indebted to the bold leadership of the President of the United States without whom we would not be transforming or improving the system.

Indeed, the bill we have just passed is nothing less than historic. By dramatically expanding opportunities for private sector innovation, it offers genuine reform that will dramatically improve the quality of health care for all seniors. At the same time, the legislation preserves traditional Medicare so that those who wish can remain in traditional Medicare and keep exactly what they have today.

This bill combines the best of the public and private sectors and positions Medicare to evolve with the medical treatments of the future. It is entirely voluntary.

I am very pleased by the overwhelming majority of this body who tonight voted to move this legislation towards a more competitive private model but a partnership between the public and private sector.

I am also pleased that the amendment maintained the balance that has been so important in what I set out a few weeks ago, to be a truly bipartisan effort. The bill devotes increased resources and expands opportunities within the traditional Medicare Program for chronic care coordination, for disease management, for preventive care.

As many people have stated, it is not a perfect bill, but we will continue to move this legislation forward now to conference once, later in the evening or in the hours of the morning, after the House passes its legislation, we will have the opportunity to make the private sector provisions more flexible, indeed more competitive, and more like the Federal Employees Health Benefits Plan. All of us in this body are familiar with the impressive record of that plan, the Federal employees plan. Every Member of Congress and over 8 million other Federal workers and retirees enjoy the ability to choose the plan that best suits their medical needs.

Indeed, as we go through conference and once the bill is signed by the President of the United States, all seniors will have that same opportunity to voluntarily choose the plan that best meets their medical needs.

I look forward to working with my colleagues on both sides of the aisle to improve this legislation and to make sure that it does not inadvertently displace good private health care coverage that exists today—options that are available to millions of Medicare beneficiaries, including employer-sponsored health coverage.

Compromise and debate are the cornerstone of this great democratic system of government. I commend my colleagues for their admirable show of bipartisan spirit. Thanks to the leadership of our colleagues in the Senate and the commitment of President Bush, America's seniors will finally receive the health coverage they need and the security they deserve.

I want to take a brief moment to thank all of my colleagues for their hard work and dedication over the last several weeks. It has been about 3 months ago that I set out that we would address Medicare for these 2 weeks—the 2 weeks prior to the July 4 recess. Many people said we were trying to do too much in too short a period of time. Others said it is something that has been debated for weeks and months, and indeed years, and there is no way we can finish it before July 4.

Yet through the hard work of our colleagues—again, on both sides of the aisle—we have fulfilled that vision. Again, it is a first step, a step that will be improved in that conference before us. Nevertheless, we succeeded in what we set out to do with the legislation that is built upon the work of many Members of the Senate, as well as the House of Representatives and, in particular, the members of the Senate Finance Committee. I do want to thank especially Senators HATCH, NICKLES, LOTT, SNOWE, KYL, THOMAS, SANTORUM, SMITH, BUNNING, and BREAUX for their hard work and leadership.

In particular, of course, I thank Chairman GRASSLEY and Senator BAUCUS, the managers, who for the last 2 weeks have so capably managed the bill on the floor. Their cooperation and their leadership has been invaluable. Without it, we would not be here so close to the finish line.

I would like to recognize all of the staff who have contributed to this effort:

First, I would like to thank my chief of staff, Lee Rawls: my policy director, Eric Ueland; and my health policy director, Dean Rosen. Paul Jacobson, Bob Stevenson, Nick Smith, Bill Hoagland, and Amy Holmes of my Leadership office also made important contributions. I also would like to recognize the other members of my health team who worked so hard to help make possible the passage of this legislation: Elizabeth Scanlon, Craig Burton, Susan Goelzer, Shana Christrup, Allison Winnike, and Jennifer Romans.

The Majority Whip's staff deserves special recognition, especially Kyle Simmons, Michael Solon, and Amy Swonger, for the long hours they put in and for the guidance they provided to our Finance Committee Chairman and our entire Republican leadership team.

As I have said, passage of this legislation was made possible in the United States Senate because of the genuine spirit of bipartisan cooperation. Both the Republican and Democratic staff of the Senate Finance Committee worked incredibly hard, long hours these past several weeks and months. Their expertise, support, and stamina has been invaluable.

I would like to thank Kolan Davis, Ted Totman, Linda Fishman, Colin Roskey, Leah Kegler, Mark Hayes, Jennifer Bell, and Alicia Ziemiecki of Chairman GRASSLEY's staff.

And I would also like to thank Jeffrey Forbes, Elizabeth Fowler, Bill Dauster, John Blum, Pat Bousilman, Kate Kirchgraber, and Andrea Cohen of Senator BAUCUS' staff for their contributions.

Hazen Marshall, Stacey Hughes, and Megan Hauck of the Senate Budget Committee staff are also commended for their efforts.

Thank you to you all.

I look forward to working with Chairman GRASSLEY and our colleagues in the House of Representatives to produce a conference report that can pass both Houses and be signed by the President in a timely manner later this year.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER TO PRINT S. 1

Mr. FRIST. Mr. President, I ask unanimous consent that S. 1, as passed, be printed.

The PRESIDING OFFICER. Without objection, it is so ordered.

(This bill will be printed in a future edition of the RECORD.)

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

INDEPENDENCE DAY

Mr. BYRD. Madam President, the Senate is poised to adjourn, but before we adjourn, I want to call us away from the onrushing press of Senate business and impending airline schedules to pay tribute to Independence Day. Next Friday is the glorious Fourth of July, that most patriotic and star-spangled of holidays. With the Fourth of July holiday, summer is at its Halcyon best, with temperatures still enjoyable, skies richly blue, and trees and lawns still lush and green, and gardens coming into bewildering abundance. In fields and along the roadsides, wildflowers bloom in profusion, and wild blackberries earn our forgiveness for their thorns by offering the tender treasures of their glossy berries.

It is a golden period of enjoyment for students on summer holiday, the respite still feels luxuriously long, full of golden days of enjoyment.

The Fourth of July this year falls on a Friday, easily making a long weekend for summer pleasure. With luck, the Fourth will be clear and cooler, comfortable for marching bands and hometown parades, bathed in glorious sunshine for family picnics and perfect for evening symphonies and fireworks to compete with the glittering stars above.

If the weather is sweltering, however, then we might be better able to empathize with the Delegates to the Second Continental Congress, who met in Philadelphia in the spring and summer of 1776. In hot and muggy summer weather, clad in heavy styles that were designed for a cooler European summer, the Delegates debated and amended, reportedly fending off flies from a nearby stable that swarmed the Hall and bit the Delegates through the silk hose on their lower legs. But they persevered in their momentous task.

On June 7, 1776, Richard Henry Lee of Virginia offered a motion to declare independence from England. His resolution declared:

> These United Colonies are and of right ought to be free and independent States.

His resolution passed on July 2 by a 12–0 vote, with New York temporarily abstaining.

The next day, on July 3, John Adams wrote to his wife, Abigail, rejoicing over the decision to secede. To Abigail, he wrote:

> The 2nd of July will be a memorable epoch in the history of America. I am apt to believe that it will be celebrated by succeeding generations as the Great Anniversary Festival.

He further suggested that it ought to be commemorated as the day of deliverance, by solemn acts of devotion to God Almighty.

This is John Adams speaking. This is not some rustic boob like I was when I came to the House more than half a century ago. Listen to him again:

> It ought to be commemorated as the day of deliverance by solemn acts of devotion to God Almighty.
>
> It ought to be solemnized with pomp, shows, games, sports, guns, bells, bonfires, illuminations, from one end of this Continent to the other, from this time forward, forever.

How remarkably prescient. Adams was off on the date, as we celebrate the approval of the Declaration of Independence rather than of the adoption of the motion, but he certainly knew how Americans like to celebrate. As well, he accurately predicted the explosive growth of an embryonic nation into a continent-spanning colossus.

That vision took great courage, coming as it did on the eve of putting his signature to a document that could easily become his death warrant. Every signer of that Declaration of Independence committed treason against England, against the King of England, against the crown. Every signer could have been arrested, put in chains and sent by boat to England; tried, convicted, and hanged. The delegates to the Continental Congress had, with this act, committed treason against the crown and set their nascent nation-state on the road to war. After the failed Jacobite uprising against England in 1745 under Bonnie Prince Charles, only 31 years before the delegate met in Philadelphia, the Scottish leaders had been beheaded in public ceremonies.

One Delegate to the Congress, John Witherspoon, put it thus:

> There is a tide in the affairs of men, a nick of time. We perceive it now before us. To hesitate is to consent to our own slavery. That noble instrument upon your table, that insures immortality to its author, should be subscribed this very morning by every pen in this house. He that will not respond to its accents, and strain every nerve to carry into effect its provisions, is unworthy of the name of free man. For my own part, of property, I have some; of reputation, more. That reputation is staked, that property is pledged on the issue of this contest; and although these grey hairs must soon descend into the sepulcher, I would infinitely rather that they descend thither by the hand of the executioner than desert at this crisis the sacred cause of my country.

What beautiful words. The signers knew full well what risks they were running.

The first anniversary of the adoption of the Declaration of Independence took place in a nation at war, with our battle fortunes at low ebb. But Americans still celebrated in Philadelphia, U.S. ships of war were decked in red, white, and blue. At 1 o'clock, each ship fired a salvo of 13 cannons to honor the 13 States. Members of Congress dined in state with other civil and military dignitaries and made toasts to liberty and to fallen patriots. After dinner, the Members and officers of the Army reviewed the troops, followed by a ringing of bells and a show of fireworks.

In 1788, Philadelphia was serving as the U.S. Capital. On that year, not only was the Declaration of Independence celebrated, but also the U.S. Constitution, which had recently been ratified by 10 States. This July Fourth celebration included another new feature—a parade with horse-drawn floats. One float, that of an enormous eagle, carried the Justices of the Supreme Court in lieu of today's beauty pageant queens.

In 1826, the Nation achieved a milestone when the 50th Independence Day celebration was being planned. The mayor of Washington wrote to invite the surviving ex-Presidents and Signers of the Declaration to attend the festivities. The five men, John Adams, Thomas Jefferson, James Madison, James Monroe, and Charles Carroll,

were unable to attend. Why? Because of age or infirmity, or other reasons. Indeed, at 10 minutes before 1 o'clock on July 4, 1826, Thomas Jefferson, principal drafter of the Declaration, passed away.

John Adams, too, breathed his last on the same day. In his 90s and gravely ill, he had determined to hold on until the 50th anniversary of independence. That morning, he roused long enough to confirm to a servant that he knew that ''it is the glorious Fourth of July. God bless it. God bless you all,'' before fading into unconsciousness. Rousing later that afternoon, he confided unknowingly as he passed on to that other shore that ''Thomas Jefferson still survives.'' He did not know that Jefferson had died earlier that day.

James Monroe, who fought in the Revolutionary War and became the fifth President of the United States, also died on July 4, in 1831. James Madison, the fourth President, died a week short of the 60th anniversary of Independence Day, on June 28, 1836.

The last living Signer of the Declaration of Independence, Charles Carroll, performed one of his last public acts on July 2, 1828. He participated in a ground breaking ceremony initiating construction of the Baltimore and Ohio Railway, the first important railroad in the Nation. He died in 1832, at the age of 95. Also in 1828, President John Quincy Adams led an unusual 4th of July parade, up the Potomac River and the old Washington Canal to the site where construction was to start on the Chesapeake and Ohio Canal. These two acts underscore the vital link between the Declaration of Independence, the Constitution which followed it, and the vibrant economy which has made and kept the United States economy vibrant and strong for so many years.

Our Nation is a union of disparate States, each of which has considerable power within its boundaries. But across those boundaries, linking the Union into a seamless web of bustling commerce and economic might, is the national infrastructure. Just as the Constitution provides for the common defense, so it promotes the common good by linking markets and people across States. Over the Years, Federal support for great infrastructure projects, from the Chesapeake and Ohio Canal to the National Highway System, have woven the Nation into a unified economic structure. Federal support for rural electrification and rural telephone and Internet access have spread opportunity and progress from border to border and coast to coast, just as John Adams foretold in 1776.

This 4th of July, as we all visit national parks, tour Federal monuments, drive on interstate highways, call friends and family around the country, and buy picnic goods grown all over the United States—as we celebrate a national Federal holiday under the protective watch of the U.S. military and Federal law enforcement agencies—we unconsciously enjoy the benefits of the Federal Government and of belonging to a union that is the United States.

Each star on the flag, the flag beside the Presiding Officer's desk, we salute so proudly represents a single state, but only when they are aligned together in the constellation of 50 do we feel the strength and the glory that were won for us, beginning on July 4, 1776. This Independence Day, we would all do well to read and cherish the Declaration of Independence. Even more, we would do well as a Nation to study and cherish our Constitution, by which our freedom, so dearly won and so costly held, lives on.

Too often in recent years and months have I seen unwise attempts to erode the checks and balances of the Constitution, unknowing or unthinking efforts to dissolve the institutions and practices established to make our Nation the free and representative government by our Founding Fathers. Attacks on the United States from without are met with instant, unhesitating defense by all Americans, but we are not so knowledgeable vigilant against the insidious weakening from within, even within this Chamber. We are all of us, with our voices and our votes, the last, best guardians of American freedom and independence. We lack only the weapons of knowledge and awareness.

I close with a poem by Henry Wadsworth Longfellow, entitled ''O Ship of State.''

Thou, too, sail on, O Ship of State!
Sail on, O Union, strong and great!
Humanity with all its fears,
With all the hopes of future years,
Is hanging breathless on thy fate!
We know what Master laid thy keel!
What Workmen wrought thy ribs of steel,
Who made each mast, and sail, and rope,
What anvils rang, what hammers beat,
In what a forge and what a heat
Were shaped the anchors of thy hope!
Fear not each sudden sound and shock,
'Tis of the wave and not the rock;
'Tis but the flapping of the sail,
And not a rent made by the gale!
In spite of rock and tempest's roar,
In spite of false lights on the shore,
Sail on, nor fear to breast the sea!
Our hearts, our hopes, are all with thee.
Our hearts, our hopes, our prayers, our tears,
Our faith triumphant o'er our fears,
Are all with thee—are all with thee!

Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

THANKING SENATOR BYRD

Mr. REID. Mr. President, I wish that I were able to express myself in a manner that is worthy of my feelings about the Senator from West Virginia. I can't do that, but I can do the best I can.

There isn't a day that goes by that I don't recognize personally how fortunate I am to live in this country and to represent the sovereign State of Nevada and to be a Member of the Senate. It is a blessing that I have had, for whatever reasons. Whether I am worthy or not, that is for someone else to determine. But one of the most important aspects of my life has been my association, my friendship, my service with the Senator from West Virginia, a man who served in the Congress for more than 50 years, who, like clockwork, comes to the Senate floor on special occasions like the Fourth of July or Thanksgiving, and makes us all feel better for having had the opportunity to listen to a speech by the Senator from West Virginia.

As I look back over the time I spent here on the Senate floor, listening to the Senator from West Virginia, I am drawn to a number of things I will never forget. I remember the speeches—and I sat with every one of them. I missed a couple of them, but I watched them in my office—the speeches on the fall of the Roman Empire that were based on the line-item veto. The Senator from West Virginia was indicating the line-item veto would be the beginning of the end of the Senate.

The Senator delivered those speeches without a note. I didn't realize at the time, but the Senator knew every word he intended to say. They were not extemporaneous in the sense I would give an extemporaneous speech. He knew before he gave the speech, beforehand, every word he was going to deliver.

I was so impressed with that series of speeches that I sent them to the head of the political science then at the University of Nevada at Las Vegas, Andrew Tuttle. Tuttle was so impressed—I sent him the speeches so he could watch them—he started a course at UNLV based on the lectures of Senator BYRD.

I am not going to go on, other than to say our country is so much better as a result of the service granted by the people of West Virginia to the Senator from West Virginia. People may not always agree with the Senator from West Virginia, but no one can take away the fact he is the epitome of the Senate. And when the history books are written—and they will be written—there will be a place where they will list the great Senators of this body, and in the top two or three will be the Senator from West Virginia.

Mr. BYRD. Mr. President, I thank my dear friend, the distinguished Senator from Nevada, who is also the Democratic whip here in the Senate.

Tennyson in Ulysses says:

I am a part of all that I have met.

Mr. President, I don't know how long the great God of the universe will spare me. But however long it may be, the distinguished Senator from Nevada, Mr. REID, will always be a part of me.

HONORING SENATOR STROM THURMOND

Mr. HATCH. Mr. President, I wish to take a minute to say a few words in

honor of Strom Thurmond, our friend and former colleague, who passed away today.

From the moment Strom Thurmond set foot in this Chamber in 1954, he has been setting records. He was the only person ever elected to the U.S. Senate on a write-in vote. He set the record for the longest speech on the Senate floor, clocked at an astounding 24 hours and 18 minutes. He was the longest serving Senator in the history of the Senate. He was also the oldest serving Senator. Many of my colleagues will recall the momentous occasion in September of 1998 when he cast his 15,000th vote in the Senate. With these and so many other accomplishments over the years, he has appropriately been referred to as ''an institution within an institution.''

In 1902, the year Strom Thurmond was born, life expectancy was 51 years—and today it is 77 years. Strom continued to prove that, by any measure, he was anything but average.

He saw so much in his life. To provide some context, let me point out that during his lifetime, Oklahoma, New Mexico, Arizona, Alaska and Hawaii gained Statehood, and 11 amendments were added to the Constitution. The technological advancements he witnessed, from the automobile to the airplane to the Internet, literally spanned a century of progress. Conveniences we have come to take for granted today were not always part of Strom Thurmond's world. Perhaps this explains why, during Judiciary Committee hearings, he was often heard asking witnesses who were too far away from the microphone to ''please speak into the machine.''

The story of his remarkable political career truly could fill several volumes. It began with a win in 1928 for the Edgefield County Superintendent of Schools. Eighteen years later, he was Governor of South Carolina. Strom was even a Presidential candidate in 1948, running on the ''Dixiecrat'' ticket against Democrat Harry Truman.

I must admit, he came a long way in his political career, given that he originally came to the Senate as a Democrat. I was happy to say that wisdom came within a few short years when Strom saw the light and joined the Republican Party.

When I first arrived in the Senate in January of 1977, he was my mentor. As my senior on the Judiciary Committee, it was Strom Thurmond who helped me find my way and learn how the committee functioned. He was not only a respected colleague, but a personal friend.

During his tenure as chairman of the Judiciary Committee, Strom Thurmond left an indelible mark on the committee and the laws that came through it. He became known and respected for many fine qualities and positions—his devotion to the Constitution, his toughness on crime, his sense of fairness.

He was famous for his incredible grip. Many of us in this Chamber had the experience of Strom Thurmond holding our arm tightly as he explains a viewpoint and asked for our support. I might add that this proved to be a very effective approach.

Strom was also known to have a kind word or greeting for everyone who came his way, and for being extremely good to his staff. Despite his power and influence, he never forgot the importance of small acts of kindness. For example, whenever he ate in the Senate dining room, he grabed two fistfuls of candy. When he returned to the floor of the Senate, he handed the candy out to the Senate pages. Unfortunately, it was usually melted into a keleidoscope of sugar by then. I have a feeling that the pages preferred it when Strom took them out for ice cream.

Strom Thurmond was truly a legend—someone to whom the people of South Carolina owe an enormous debt of gratitude for all his years of service.

Clearly, the people of South Carolina recognize the sacrifices he made and are grateful for all he did for them. In fact, you cannot mention the name Strom Thurmond in South Carolina without the audience bursting into spontaneous applause. He truly was an American political icon.

Abraham Lincoln once said that ''The better part of one's life consists of friendships.'' With a friend like Strom Thurmond, this sentiment could not be more true. I am a great admirer of Strom Thurmond, and I am proud to have called him my friend.

One final note about Strom Thurmond. He was a great patriot. A decorated veteran of World War II who fought at Normandy on D-day, Strom Thurmond loved this country. Let me close by saying that this country loved him, too.

A SALUTE TO PAUL GALIS

Mr. BYRD. Mr. President, the great State of West Virginia has produced numerous individuals who have dedicated their lives to the service of the Nation. These sons and daughters of West Virginia have contributed to the betterment of their communities, their State and their country. One such public servant is Paul L. Galis, who for 35 years has served admirably in the Federal Aviation Administration, and has contributed to the development of an aviation system unsurpassed in the world.

Mr. Galis retires in July as the Deputy Associate Administrator for Airports in FAA. In this position as well as his previous position of Director of the Office of Airport Planning and Program, Mr. Galis has overseen the planning and development of over 3,000 airports in the national plan for airports. This has been no small task and Mr. Galis has served with distinction.

All of us in the State of West Virginia salute Mr. Galis for his career and wish him the best in his future endeavors. Our country is better for the work he has done and the example of public service he has provided. His able leadership and steady hand will be missed.

OREGON'S TANF WAIVER

Mr. WYDEN. Mr. President, on June 12, 2003, I published a notice in the CONGRESSIONAL RECORD of my intent to object to moving to H.R. 2350, a bill to extend the Temporary Assistance for Needy Families, or ''TANF,'' our Nation's welfare program. My good friend from Oregon, Senator SMITH, joined in this effort because the legislation does not contain a provision critical to Oregon's welfare program: a waiver of certain provisions that gives Oregon flexibility to operate a successful welfare program. Because of its waiver, which expires on June 30, 2003, Oregon has reduced its welfare rolls nearly 60 percent since 1994. It is clear that the waiver has allowed Oregon to meet local needs and craft what has been heralded as one of the best welfare programs in the country.

Since Senator SMITH and I announced our public holds, the distinguished chairman of the Finance Committee, Senator GRASSLEY, and the ranking member, Senator BAUCUS, have worked closely with us to find a way so that Oregon can continue to operate under its waiver until TANF is fully reauthorized. They have helped obtain a letter from Department of Health & Human Services Secretary Tommy Thompson to Oregon Governor Ted Kulongoski, myself and Senator SMITH assuring us that Oregon can continue to operate without penalty under its waiver. I believe this letter provides Oregon the assurances necessary to continue to operate as if the waiver were still in place, and ask unanimous consent to insert the letter in the RECORD.

Mr. SMITH. I join Senator WYDEN in expressing deep pride in Oregon's TANF program and in thanking the chairman and ranking member of the Finance Committee, on which I serve, for their cooperation. I share his assessment that this letter will enable Oregon to maintain its TANF program without penalty until the program is reauthorized.

I also express my appreciaiton to Senators GRASSLEY and BAUCUS for their efforts on TANF reauthorization. We have been working together for months to ensure that all TANF proposals, including those elements which have made Oregon's TANF program so successful, are carefully considered as we move toward TANF reauthorization.

Oregon's TANF program, often called the Oregon Option, works because it recognizes local barriers to work and works with individuals to asses their needs and get them onto a path toward independence. For example, Oregon allows individuals with severe substance abuse problems to seek treatment. This helps people address the root of their problems—not just the symptons. The

Oregon Option has put people into real work situations—not just make work—and this has helped Oregon move people off the welfare rolls and into real, sustainable jobs. I believe the Senate can learn from the lessons of Oregon's program, and I will continue to work with my colleagues to ensure that all state TANF programs have the flexibility they need to operate successfully.

Mr. GRASSLEY. Mr. President, I understand the concerns of the Senators from Oregon, and look forward to working with them to reauthorize the TANF program in the coming months. I appreciate their concern for the need for Oregon to retain flexibility in TANF. I hope the Senator from Montana will agree that the Finance Committee, on both sides of the aisle, should discuss this issue as we move to reauthorize the TANF program.

Mr. BAUCUS. I agree with the chairman and look forward to moving on these issues. My home State of Montana is currently operating under a waiver that expires on December 31st of this year. I know that Montana, like Oregon, has been able to craft a successful TANF program because of its waiver, and I look foward to working with my distinguished colleagues to see that it is retained.

RECOGNIZING SENATOR TED STEVENS, THE RECIPIENT OF THE ARLEIGH BURKE AWARD FROM THE CENTER FOR STRATEGIC AND INTERNATIONAL STUDIES

Mr. INOUYE. Mr. President, our distinguished colleague, the Honorable TED STEVENS, was presented with the Arleigh Burke Award on June 11, 2003, by the Center for Strategic and International Studies. The award, named after the famed Admiral, who was the longest serving Chief of Naval Operations, recognizes Senator STEVENS's leadership in the fields of strategy, resources, and maritime affairs, as well as his hard work and selfless dedication to promote public service and the ideals of freedom.

When Senator STEVENS accepted the Burke Award, he delivered a thoughtful speech that underscored Admiral Burke's conviction that duty to country is more important than duty to the Commander-in-Chief, and that we should oppose the concentration of power.

I ask unanimous consent that Senator STEVENS's speech be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SPEECH BY SENATOR TED STEVENS AT THE CSIS ARLEIGH BURKE MEMORIAL DINNER ON JUNE 11, 2003, IN WASHINGTON, DC

Good evening. Thanks to my good friend and colleague Senator Warner for that warm introduction.

My congratulations to General Keene, the Army's new Acting Chief of Staff. I wish him success in the coming months.

It is a tremendous honor to receive an award named after Admiral Burke. Like many of you, I am familiar with the Admiral's distinguished life of dedication, service, and achievement. When I served in China during World War II, he was an admiral in the Navy, and the battles that made him one of that war's greatest combat leaders were well-known.

I met Admiral Burke during the Eisenhower Administration. I was working on statehood for Alaska and Hawaii in the Department of Interior in those days. Admiral Burke was the Chief of Naval Operations. Like everything he did, Admiral Burke served as CNO with tremendous distinction. He was the youngest and longest serving CNO in history, and during his tenure he fought for technologies and strategies that continue to form the foundation of our Armed Services.

To refresh my memory of Admiral Burke's accomplishments, I went back to E.B. Potter's book about him.

Potter reported that in January of 1958, the year Alaska's Statehood Bill was enacted, Burke opposed the Gaither Report, which recommended streamlining and centralization of defense. At the National Press Club he warned against control of all U.S. forces by ''one man, a military Solomon.''

Notwithstanding that position of the CNO, in April 1958, and I quote from Potter's book on Arleigh Burke:

''. . . Eisenhower sent to Congress a special message on reorganization of the Department of Defense. Its chief recommendations were (1) to remove the Service Chiefs from the operation chain of command; (2) to restrict Service Secretaries to administration, relieving them of responsibility for military operations; (3) to restrict duties of Joint Chiefs of Staff mainly to advising the Secretary of Defense; (4) to enlarge the Joint Staff; and (5) to limit control of operating forces to the President and the Secretary of Defense.''

Eisenhower sent word through Secretary of Defense McElroy that he wanted all senior officers and officials to support his plan.

Arleigh was called before the Senate Armed Services Committee. As Potter stated, Admiral Burke ''put duty to country over duty to the Commander-in-Chief,'' and opposed this concentration of power in the Secretary of Defense.

The Defense Reorganization Act of 1958 did not rubber stamp the Gaither Report. It followed many of Admiral Burke's suggestions.

To his great credit, Ike appointed Admiral Burke to a third term as CNO in August 1959.

It is my hope that in reviewing the current proposals from D.O.D. before Congress, senior officers and officials of D.O.D. and all members of Congress will follow the great traditions Admiral Burke upheld.

Arliegh Burke lived his life by principles which guided him through the perils of World War II and still pertain today.

He once described his philosophy as:

''An old-time philosophy—a philosophy of realism. You must always ask yourself the question, 'What is important in life? . . . I don't think it's very important to be remembered. . . . The ideas I stood for should be remembered.''

Admiral Burke also demonstrated his loyalty to the men under his command. The spirit of Admiral Burke's commitment to his sailors is reflected in the steps the Congress has taken to support our troops and honor our promises to our veterans.

Admiral Burke was a hero and a visionary, and I can think of no greater honor than to be your guest at this evening's event. Thanks again for this award.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in New Bedford, MA. On June 22, 2003, Saurabh Bhalerao, a 24-year-old graduate student, was ambushed by four men and savagely beaten when the assailants mistook the student for a Muslim. Mr. Bhalerao, a Hindu Indian, works parttime as a pizza delivery man. One of the suspects placed a phone order at the local pizzeria where Mr. Bhalerao is employed. When Mr. Bhalerao arrived with the order, two men shoved him into the apartment and pushed him to the floor. After Mr. Bahlerao was lying on the floor, the attackers kicked and beat him. At one point, one suspect hit him with a kitchen chair. The perpetrators also burned Mr. Bhalerao's body with lit cigarettes. According to court documents, one of the attackers told Mr. Bhalerao to ''Go back to your own country.'' Mr. Bhalerao eventually escaped from the trunk of an assailant's car after he managed to loosen the fisherman's rope binding his hands and feet. He is currently in the intensive care unit at a local hospital.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

NOMINATION OF JOSHUA BOLTEN TO BE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET

Mr. CONRAD. Mr. President, I rise in support of Joshua Bolten as Director of the Office of Management and Budget, and to urge Mr. Bolten to do everything within his power to help put the Federal budget back on sound footing.

The position of OMB Director is always one of the most demanding posts in our Government, but it is especially so right now. The tax cuts pushed through by the President over the last 2½ years, combined with the continuing economic slowdown and increased spending to respond to the September 11 terrorist attacks and prosecute the military efforts in Afghanistan and Iraq, have pushed the budget deep into deficit. And despite the fact that we desperately need to get our fiscal house in order to be ready for the imminent retirement of the baby-boom population, this administration and its allies in Congress have not yet accepted that the policies they have advocated are leading us in the wrong direction.

I support the nomination of Joshua Bolten as OMB Director because I believe he is a very capable and honorable man, with a distinguished record both in public service—including service as a Senate staffer—and in the private sector. I sincerely hope he will take to heart the duty of the OMB Director to be an advocate for fiscal responsibility—to be willing to present the President with the facts where the budget is heading even if those facts are unpleasant, and to recommend policies to the President that will put the budget back on a sustainable path even if those policies may be politically difficult.

In a written response to a question by the Governmental Affairs Committee, Mr. Bolten reiterated the position of the Bush administration about the deficits facing us, stating that: ''Our current deficit—as measured as a percentage of gross domestic product (GDP)—is not large by historical standards and is manageable within the overall context of our economy.''

I hope when Mr. Bolten assumes his post as head of OMB, he recognizes the reality of the budget situation and leads the administration to reassess that position. That reality is that the deficit we are currently facing is enormous by any standard. According to CBO, the total deficit will exceed $400 billion this year, more than $100 billion higher than the all-time record deficit of $290 billion recorded in 1992. As a percentage of GDP, the deficit will be about 4 percent, a level that has been reached only eight times in the 57 years since the end of World War II. More troubling, when Social Security is excluded from the calculation, this year's deficit is likely to total about 5.5 percent—a level reached only twice in the last 57 years.

I hope Mr. Bolten accepts how serious the budget situation is and how important it is that we do not delay beginning to deal with the situation. I hope that he will advise the President to work with the Congress in a truly bipartisan way to reach agreement on and enact policies that will put the budget back on track.

COMBATING TORTURE AND ASSISTING VICTIMS OF TORTURE

Mr. CAMPBELL. Mr. President, I rise to address the barbaric practices that constitute torture as we mark the United Nations Day in Support of the Victims of Torture. Astonishingly, an estimated 500,000 victims of torture live in the United States today, including many in my home State of Colorado. The United States has provided vital leadership in the campaign to prevent torture around the world. The United States must not equivocate on this most basic of human rights.

While the United States has consistently spoken out forcefully against the use of torture around the world, serious questions have been raised suggesting U.S. complicity in torture as part of the war against terrorism. This prompted me to join other members of the Helsinki Commission in writing to the White House recently urging an investigation of ''serious allegations that the United States is using torture, both directly and indirectly, during interrogations of those suspected of terrorism.'' Against this backdrop, I urge the administration to issue a forthright statement on torture. In his State of the Union Address, President Bush described the horrific forms of torture employed by the Hussein regime and concluded, ''If this is not evil, then evil has no meaning.'' Even as experts document the scope of torture in Iraq, there must be no doubt concerning U.S. policy and practice.

As Cochairman of the Helsinki Commission, I am particularly concerned that torture remains a tolerated if not promoted practice by come countries, even within the membership of the 55-nation Organization for Security and Cooperation in Europe, OSCE.

In some places, like Uzbekistan, members of the political opposition or religious minorities are especially likely to be the victims of torture. Tragically, two more people there have joined the long list of those who have died in custody amid credible allegations of abuse and torture, just weeks after the European Bank for Reconstruction and Development hosted a prestigious meeting in Tashkent, and days after the Secretary of State determined Uzbekistan is eligible for continued U.S. assistance. Moreover, the shortsighted practice of making martyrs out of Islamic extremists may have exactly the opposite effect the government claims to be seeking in its efforts to combat terrorism.

In Georgia, torture and abuse comes hand in hand with police corruption. In the most recent State Department Country Report on human rights in Georgia, the Department stated: ''[s]ecurity forces continued to torture, beat, and otherwise abuse detainees. . . . NGOs also blamed several deaths in custody on physical abuse, torture, or inhumane and life-threatening prison conditions.'' Even President Shevardnadze has, in the past, acknowledged the prevalence of abuse against detainees and prisoners. I welcome a new initiative of the OSCE Mission in Georgia to combat torture, but I would also note that antitorture initiatives have come and gone in Georgia with little to show for it. Without real political will, I am afraid this latest initiative may end up like the others.

In Turkey—a country which has been given particular attention by the Helsinki Commission—even the doctors who treat the victims of torture have become targets themselves. Their offices have been raided, records seized, and even some doctors have been arrested and tortured. Moreover, the patients of these doctors, all of whom have already suffered at the hands of the authorities, have often been rearrested, retortured and recharged based on their testimonies given to the medical authorities.

As a result of these practices, Turkey has been repeatedly sanctioned by the European Court of Human Rights. The Turkish nongovernmental organization, the Human Rights Foundation, appears to be making some headway in defending these doctors. Last year, Turkey's Grand National Assembly has passed significant legislation with severe penalties for those convicted of torture. A major effort still needs to be made to conform the application of the law in the regional courts of Turkey with the intent of the parliamentarians. The Helsinki Commission will continue to monitor developments in Turkey and the implementation of this law.

In the 1999 OSCE Istanbul Charter, the participating States committed themselves to ''eradicating torture and cruel, inhumane or degrading treatment or punishment throughout the OSCE area. To this end, we will promote legislation to provide procedural and substantive safeguards and remedies to combat these practices. We will assist victims and cooperate with relevant international organizations and nongovernmental organizations, as appropriate.''

Clearly a strategy to confront and combat torture must emphasize prevention of torture, prosecution of those who commit torture, and assistance for the victims of torture. As we mark the United Nations Day in Support of the Victims of Torture, I note the good work being done by the Rocky Mountain Survivors Center, located in Denver. The center is part of a nationwide network committed to assisting the victims of torture living in the United States.

HONORING PRIVATE FIRST CLASS MICHAEL DEUEL

Mr. JOHNSON. Mr. President, I am saddened to report the passing of Private First Class Michael Deuel of Nemo, SD. Pfc. Deuel was killed on June 18, 2003, while serving in Operation Iraqi Freedom.

Michael moved from his home in Cheyenne, WY to attend school at Boxelder Job Corps in South Dakota in May 2000. His friends and teachers described him as an unassuming, yet confident student. Focused and hard working, Michael was determined to perform well in school. He received his general education diploma and certification from the culinary arts program shortly before enlisting in the Army. Following service in the military, he dreamed of becoming a chef and owning his own restaurant.

After enlisting in the Army, Michael entered airborne school to become an Airborne Ranger. He went on to Army Ranger School and became a member of the Army's 325th infantry regiment of the 82nd Airborne Division, which is based in Fort Bragg, NC.

On February 13, 2003, he was deployed to Iraq. While protecting a propane-distribution center in Baghdad, he was killed by enemy fire.

The lives of countless people were enormously enhanced by Michael's goodwill and service. Although he did not live to see his dreams realized, he continued to inspire all those who knew him. Our Nation and South Dakota are far better places because of his life, and the best way to honor his life is to emulate his commitment to our country.

I join with all South Dakotans in expressing my sympathies to the family of Private First Class Deuel. I know he will always be missed, but his service to our Nation will never be forgotten.

NEW HOMESTEAD ECONOMIC OPPORTUNITY ACT

Mr. SMITH. Mr. President, I rise today with great concern. As you are aware, President Bush named June National Homeownership Month 2003. I am proud that our President has seen fit to promote an aggressive homeownership campaign, and I support this administration's efforts to see more Americans reach the American Dream of homeownership. As a member of the Finance Committee, I have had the opportunity to learn of important ways that we can make that a reality. In January I introduced the New Homestead Economic Opportunity Act, better known as the Homeownership Tax Credit. This legislation will create a single-family housing tax credit for developers who build in low income areas, and allow more Americans to reach their dreams of homeownership. It will also encourage developers of single family units to invest in low income areas and improve our communities.

The Department of Housing and Urban Development has stated that one of its goals is to allow every citizen—regardless of race, creed, color, or place of birth—the opportunity to own their own home. To reach this goal, there must be affordable homes to purchase.

In his testimony before the Senate Committee on Banking, Housing, and Urban Arrairs earlier this month, James Rayburn, the Vice President of the National Association of Home Builders stated that the Homeownership Tax Credit proposal seeks to close the gap in homeownership rates among Americans. While 82 percent of households earning 100 percent or more of the national median income now own homes, only 53 percent of households earning less than the national median are homeowners. The homeownership rate for families earning 80 percent or less of the national median is only 40 percent to 45 percent. Homeownership for whites is 75 percent, while the ownership rate for African Americans is just below 48 percent and 48 percent for Hispanics.

We can all agree that the quality of life in distressed neighborhoods can be improved dramatically by increasing home ownership. Existing buildings in these neighborhoods often need extensive renovation before they can provide decent owner-occupied housing. It is also difficult for renovations to occur because the costs involved exceed the prices at which the housing units could be sold. Similarly, the costs of new construction may exceed its market value. Properties sit vacant and neighborhoods remain devastated. The New Homestead Economic Opportunity Act bridges the gap between development costs and market prices and will revitalize these areas.

I would like to see every American given the opportunity to succeed at the goal of owning their own home. I am proud to be the sponsor of this legislation, and I plan to continue to work to see it become law. I urge my colleagues to join me in supporting the American Dream by supporting S. 198.

HONORING MAYNARD H. JACKSON, JR.

Mr. CHAMBLISS. Mr. President, as Atlanta's first black mayor, Maynard Jackson dedicated his career and his life to healing the racial inequalities that surrounded him and ensuring that the city of Atlanta was a thriving, inclusive community.

Working to expand Hartsfield International Airport, Maynard fought for equal treatment for minority workers and businesses. He sought to bring diversity to government as well as Atlanta's business community. Through the equality he sought for all racial groups, he was able to foster economic expansion and growth for Atlanta and greater equality for her citizens.

Working to secure the 1996 Olympics, Maynard ensured that Atlanta shined for the world and was recognized as a city that offered opportunity for everyone regardless of race or socio-economic class.

Serving as the president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials, he became a role model for young African Americans hoping to someday make their mark on this world and worked tirelessly to improve interracial relationships in the South's largest city.

His contributions and accomplishments to help our State thrive economically and to expand opportunities for minorities will be remembered for generations to come. The legacy he leaves behind is one of a greater respect for all people, greater opportunity for all people and greater hope for the world.

Our thoughts and prayers are with his loved ones left behind, and his memory will forever be with us.

IN SUPPORT OF THE PLEDGE OF ALLEGIANCE

Mr. ALEXANDER. Mr. President, recently, I visited with Reverend Jacob Bazzel Mull and his wife, Elizabeth, in Knoxville, TN. They host the Mull Singing Convention, a popular gospel radio program.

Reverend Mull is a legend with an interesting story to tell. He was born in 1914 in Burke County, NC, into a musical family. When he was 11 months old, he lost his eyesight after falling into an open-pit fireplace. As a child, he played in a gospel group made up of his mother, father, brothers and sisters.

He began preaching in 1939 and hasn't stopped since. In 1942, he moved to Knoxville to start his first radio program, and the rest is history. He became well-known nationwide during the 25 years he sold Chuck Wagon Gang Records on several 50,000-watt radio stations.

This year, all of his many accomplishments were recognized when he was honored by the Gospel Music Association for his ''outstanding contributions to gospel music.''

During our visit in April, Reverend Mull gave me 2,000 letters and a number of petitions with thousands of names on them from Americans angry over the Ninth Circuit's decision declaring the Pledge of Allegiance unconstitutional. Reverend Mull solicited these letters from his listeners across the country, and I was delighted to see the passion people across America have for the Pledge. It made me proud to answer all of those letters.

It is inspiring to me that every day Reverend Mull brings out the best in America. He challenges us to think, and he encourages us to be involved in issues. He also reminds us to turn to our religious faith for guidance. I ran for the U.S. Senate because I wanted to find out how to bring out the best in people in Tennessee and across this country, all day, every day.

I believe the answer to how we do that lies with the people. In August of 2002, I spent the night with Jim Coley, a Tennessee Government high school teacher, and his family. One idea that came out of that visit was the importance of putting the teaching of American history and civics back into our classrooms. From that discussion, we came up with the framework for the American History and Civics Act of 2003 that just passed the Senate.

The bill establishes summer residential academies for teachers and students to encourage the teaching and learning of American history and civics in a more inspired way than is happening today. We can't expect our students to learn what it means to be an American if we don't teach them.

I would also like to see students in every classroom across this Nation beginning each schoolday with the Pledge of Allegiance. That could be followed with a student or teacher explaining in his or her own words what it means to them to be an American.

After the terrorist attacks of September 11, 2001, we saw how quickly we Americans could come together as one people, united in purpose, despite our

diverse backgrounds. Although we are almost 2 years removed from that time, there is no reason this sense of unity and purpose cannot continue as part of our lives every day. Americans have a reputation for being resourceful, resilient, and having common sense. These are good qualities for helping to bring out the best in the entire Nation.

I thank Reverend Mull for his commitment to this country, for inviting me to visit with him, and for sharing American's outpouring of support in favor of the basic values and principles on which this Nation was founded. I also appreciate the opportunity to bring Reverend Mull's good work to the attention of our country.

WELCOME BACK TO ALASKA, MR. CONSUL GENERAL

Ms. MURKOWSKI. Mr. President, next week the people of Alaska will welcome Mr. Yossi Amrani, the Consul General of the State of Israel for the Pacific Northwest, back to our State. He will begin his trip in Fairbanks, meeting with students and members of the community at the University of Alaska, visiting with members of Congregation Or Hatzafon, which has the northernmost synagogue building in the world, and speaking to the Greater Fairbanks Chamber of Commerce. He will also visit Anchorage on this trip and I look forward to meeting with him then.

This is not Mr. Amrani's first visit to my State, but it is his first visit to Fairbanks, the ''Golden Heart City.'' Although the Fairbanks Jewish community is small in numbers, the fundamental Jewish values of tikkun olam, making the world a better place; tzedakah, charity; and chesed, kindness, are deeply ingrained in the Fairbanks culture, as they are in the culture of Alaska as a whole.

Like the Fairbanks Jewish community, the Alaska Jewish community is small in numbers, but large in spirit. In the late 1990s, Professor Bernard Reisman from Brandeis University visited Alaska on several occasions to learn more about our Jewish community. He concluded that in virtually all areas, the Alaska Jewish community has a higher level of identity than do American Jews generally. He found this to be true not only in places like Anchorage, Fairbanks and Juneau, which have functioning congregations, but also in the smaller communities, where ''conveners'' organize regular get togethers, especially on Jewish holidays.

Members of the Jewish community occupy a prominent role in the social, economic, cultural and political life of Alaska. A few weeks ago, I welcomed the internationally known holocaust scholar, Dr. Michael Schuldiner of the University of Alaska Fairbanks, to my office in Washington. Dr. Schuldiner discussed his work with the United States Holocaust Memorial. Another UAF scholar, Dr. Michael Krauss, has worked closely with the Alaska congressional delegation for many years in efforts to preserve Alaska Native languages. And let us not forget the many contributions of the Gottstein family to virtually every aspect of Alaska's fabric.

This is not a new phenomenon. The beautiful municipal library in Anchorage is named for Zachary J. Loussac, a Russian Jewish immigrant, who served as Mayor of Anchorage. The Girl Scout camp in Fairbanks is named for Jessie Bloom, who along with her husband Robert, are regarded as the founding leaders of the Fairbanks Jewish community. In 1926, Jessie started the first Girl Scout troop in Alaska, while Robert was a founder of what was later to become the University of Alaska. Our striking new courthouse in Fairbanks is named for Jay Rabinowitz who served for many years on the Alaska Supreme Court.

The survival of the State of Israel is important to the people of Alaska as it is to the American Jewish community and the American people. In Washington, I stand shoulder to shoulder with my colleagues in praying for peace in the Middle East while standing firm on the principle that terrorism is morally and politically unacceptable. Terrorism will not undo Israel's future. When the Senate returns in July, it will consider comprehensive energy legislation and I am hopeful that my amendment to guarantee that Israel will have a secure source of petroleum in the event it cannot independently acquire it due to an embargo will be in the bill when it passes the Senate.

During this visit to Alaska, as on previous visits, the Consul General will encounter the vast natural beauty of our state. But he will also discover, as in previous visits, that it is the people of Alaska that make this place truly special. Shalom, Mr. Consul General. I hope that you will visit with Alaskans often.

Mr. President, I ask unanimous consent that the message of Consul General Yossi Amrani be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MESSAGE OF CONSUL GENERAL YOSSI AMRANI TO THE PEOPLE OF ALASKA

The friendship and alliance between the United States and Israel have many varied faces, moral, political, economic and strategic. The partnership is on the federal and state level alike. Israeli consulates in the country, local Jewish communities together with state level administrations aim at fostering and nurturing the relationship for the benefit of both countries. In the state of Alaska, thousands of miles apart, the Consulate General of Israel to the Pacific Northwest Region works with state leaders and the Jewish community to bring the two nations together in sharing the values, ideals and concerns of both people. The Consulate provides seminars and speaking engagements in different campuses, churches and temples to educate public opinion on the complexity of the situation in the Middle East and the importance of the U.S. role in that region. The Consulate also promotes Israeli culture and business opportunities. Mutual values are the corner stones of the relationship and affinity between the people of Alaska and Israel. As we maintain U.S. support for Israel's existence and well being, we aspire to continue building stronger relations.

HONORING THE LATE DAVID BRINKLEY

Mrs. DOLE. Mr. President, I am honored today to talk about a pioneer for North Carolina in the field of journalism . . . the late David Brinkley. David died on June 12, at the age of 82, from complications resulting from a fall. He was laid to rest in his beloved home, Wilmington, North Carolina . . . beside his father—William Graham Brinkley and mother—Mary MacDonald West Brinkley.

David was born in Wilmington . . . He attended high school at New Hanover High School. While there . . . and after several long hours pouring over books in the Wilmington Library . . . David got an itch for journalism.

He didn't wait. He took a part-time job while still in high school, working for the Wilmington Morning Star and its afternoon edition, the Wilmington News. He said he made about $11 a week.

But the young boy, who once made extra money by changing light bulbs and running a soft-drink stand at Wrightsville Beach's Lumina Pavillion, went on to become an icon for millions of viewers who watched him each night. He and co-anchor Chet Huntley had the highest rated news program on American television during the 1960's with ''The Huntley-Brinkley Report.'' Many of us still remember their familiar sign-off of ''Good night, Chet,'' ''Good night, David.''

David went on to host ''This Week With David Brinkley,'' until he retired in 1996.

Mr. President, at a time when we often get news that is too short, too sensationalized and sometimes too slanted, David Brinkley was the consummate newsman. He knew the issues, and his intelligence, quick wit and thirst for answers kept us all glued to the television.

I had the pleasure of personally knowing David Brinkley, and in addition to sharing a distinctive Southern twang, we shared a fondness for our home state. David wrote about Wilmington in his 1995 memoirs and even with all this success, all his fame, David and his wife, Susan, returned to his home in North Carolina often and supported his hometown. He was an ardent supporter of downtown Wilmington preservation. The University of North Carolina at Wilmington presented him with an honorary Doctor of Letters degree in 1974. He was added to Wilmington's Walk of Fame in 2001.

As much as David loved North Carolina—North Carolina loved him, too.

His life has been a model for so many North Carolinians—the local boy doing good . . . remembering his roots.

We will forever be indebted to David Brinkley for solid Washington reporting and his wry sense of humor. The Senate passed a resolution, which I cosponsored, honoring the life and accomplishments of David Brinkley. May his legacy live on and inspire those who follow in his footsteps.

In an interview 11 years ago, David said this of his profession, ''People go and find out what is happening, and then tell what they have seen. That's all a reporter ever did. I think it's a very honorable thing to do.''

Indeed, it is, David, indeed, it is.

Mr. President, I send out my heartfelt condolences—and those of all North Carolinians—to Susan and to David Brinkley's family.

ADDITIONAL STATEMENTS

WIND RIVER INDIAN RESERVATION'S 140TH ANNIVERSARY

• Mr. THOMAS. Mr. President, I rise today to recognize the 140th Anniversary of the Wind River Reservation.

On July 2, 1863, the U.S. Government and the Shoshone people signed the Fort Bridger Treaty, creating the Shoshone Reservation, which included over 44 million acres in what is now Colorado, Utah, Idaho, and Wyoming. This area was reduced to roughly 3 million acres by the second Fort Bridger Treaty of July 3, 1868, and was later renamed the Wind River Reservation during the 1930s. Today, the reservation is roughly more than 2 million acres, one of the largest in the country, and is located in central Wyoming's beautiful Wind River Basin. It remains the contemporary home of the Eastern Shoshone and Northern Arapaho tribes.

Chief Washakie, a distinguished statesman of the Shoshone people, was one of the few Indian leaders to successfully negotiate with the U.S. Government in determining the reservation's location. For centuries, American Indians who traveled through this area referred to it the Warm Valley of the Wind River because of surrounding hot springs. Renowned for his courage on the battlefield, and talent in diplomacy, the people of Wyoming selected Chief Washakie to represent our State, in the U.S. Capitol Building, as one of our two contributions to Statuary Hall.

The northern band of Arapahos began to make the Wind River Reservation a more permanent home during the last 1870s, though they were not signatories to either of the Fort Bridger Treaties. Under the leadership of men such as Black Coal, Sharp Nose, Little Wolf and White Horse, the Northern Arapahos settled in Wyoming, while the southern band of Arapahos was moved to a reservation in western Oklahoma. Wind River country encompasses mountains, streams, lakes and forests, and was favored by the Northern Arapaho over the hot and arid Oklahoma landscape.

The Wind River Indian Reservation is one of Wyoming's great historical, cultural, and natural treasures. A grave site for Sacajawea, the young Shoshone woman who helped guide the Lewis and Clark expedition through Shoshone lands in the early 1800s, can be visited on the reservation. Both tribes continue to host several powwows during the spring and summer months that draw visitors and members of tribes from across the country. Later this week, the Eastern Shoshone will be celebrating the Treaty Days Powwow.

As we look back on the past 140 years, I would like to pay tribute to the important contribution American Indians have made to our history and our culture. Throughout my time in Congress, I have had the pleasure to work with tribal leaders from both tribes on the Wind River Reservation. I would like to thank Vernon Hill, chairman of the Eastern Shoshone Business Council and Burton Hutchinson, Sr., chairman of the Northern Arapaho Business Council, for their leadership as we work to ensure the prosperity of the Wind River Reservation for future generations.•

A GREAT MONTANAN—ANTHONY J. PREITE

• Mr. BAUCUS. Mr. President, I rise today in celebration of a great Montanan and American, Anthony J. Preite.

Today, Mr. Preite, the director of the Denver Regional Office of the U.S. Department of Commerce Economic Development Administration is retiring. I have known Tony Preite for about 30 years. He was raised on Montana's ''High Line'' in Havre, MT. After a short time as a high school teacher and coach, he was lured by the Bear Paw Development Corporation, an EDA designated economic development district, to come to work for them in 1968. A year later, he became the executive director of that fledgling organization and thus began a career in economic development that is virtually unparalleled today. Under Tony's leadership, Bear Paw Development Corporation quickly developed a reputation as one of this Nation's premiere economic development organizations. Tony spearheaded literally hundreds of economic and community development projects and programs in that part of northern Montana. These projects resulted in hundreds of jobs, scores of infrastructure improvements, and other activities that have improved the lives of people in that area. Among his other accomplishments at Bear Paw, he was a founding member of the Montana Economic Developer's Association, served on the Montana Private Industry Council, and was chairman of the Governor's Economic Development Council.

Tony's work at Bear Paw Development Corporation was so successful that I felt the need to bring the benefit of his expertise and enthusiasm to more Montanans. That is why, in 1993, I recommended his appointment by President Clinton as State Director of the Montana Farmers Home administration. Through a reorganization at the U.S. Department of Agriculture, Tony led a successful transformation of the Farmers Home Administration Agency to the current Rural Development agency. While at the U.S. Department of Agriculture, Tony served on many national committees within the rural Development Agency, helping to guide the agency during its formative years. The success of the Rural Development Agency and the value of its programs today are largely due to the efforts that Tony made during his tenure there.

In December 1999, Tony accepted the position as Regional Director for the economic Development Administration. In this position, Tony has continued to impart his expertise and enthusiasm to a 10 State region. In his professional life, Tony has received accolades and awards too numerous to mention here. Instead, let me say that I have not met anyone as dedicated to public service as Tony Preite. Tony does not leave his work at the office. He lives and breathes ''public service'' every day, all day. It's immediately apparent to anyone who meets him that he always cares about the people he serves. His works has made an enormous difference for Montana and for all of us who work and play there.

While Tony's retirement is a sad occasion to all of us who work with him, it is well deserved. I can take comfort that he will be returning to Montana and that he will find some other way to continue to serve his State. I wish Tony and his wife Betty all the best and I thank him for more than 35 years of public service. Good luck, Tony, and welcome back to Montana!•

AL BRAIMAN: DEPAUL UNIVERSITY CLASS OF 2003

• Mr. DURBIN. Mr. President, I rise today to honor Al Braiman, graduate of DePaul University's Class of 2003. Al was the oldest graduate of DePaul's Class of 2003 when he graduated on June 14. Al completed a degree in liberal arts at DePaul's College of New Learning with a grade point average of 3.92 out of a possible 4.0.

Born in Kiev, Russia, in 1920, Al immigrated to the United States at the age of one. His family took up residency in Chicago, where he lived most of his life. After high school, Al turned down an academic scholarship for college to support his family. Al joined the Army and served with distinction in World War II, spending most of his time on Guadalcanal.

After leaving the Army, Al owned and operated Lakeview Grocerland until the mid 1960s when he became an insurance salesman with Equitable Life

Insurance Company. He became a certified life underwriter and chartered financial consultant. Al won many awards in the industry, including induction into the Equitable Hall of Fame.

After retiring in 1985, Al decided to earn a college degree, something he promised his mother earlier in his life. Al's interest in politics led him to take many political science and history courses at DePaul University. Some of his favorites included a class on American presidents and a course on race relations. He also enjoyed learning many new things such as use of the Internet, photography, and art. Al has proven that it is never too late to learn and we could all learn a great deal from his perseverance.

I know my fellow Senators will join me in congratulating Al Braiman, DePaul Class of 2003. His story contains all the elements of a great American life and I am honored to share it with my colleagues in the Senate.●

HONORING SUPERINTENDENT GERALD WAYNE COBB, ED.D

● Ms. LANDRIEU. Mr. President, every session in Congress we spend a large amount of time discussing education in this country. Debates range from accountability to school construction to teacher recruitment. While our discussions are of the utmost importance, it is the implementation of our decisions by the individuals within the education system that changes how our children learn. Today I rise to honor a man who had dedicated his life to improving education for children in Louisiana, Dr. Gerald Wayne Cobb.

In 1960, Dr. Cobb received his bachelor's degree in health and physical education from Louisiana Tech University. Since that time he has been a crucial part of school improvements within the Lincoln Parish School System. Dr. Cobb has served as principal of Hillcrest Elementary School, Simsboro High School, and Ruston High School. He has worked as visiting associate professor at Louisiana State University and Louisiana Tech University.

Dr. Cobb has also served in the Louisiana Department of Education, working as the director of secondary education, the executive director of academic programs, and the executive assistant to the superintendent. While with the Louisiana Department of Education, Dr. Cobb was instrumental in developing the Compensatory Education Program in Louisiana which provided remediation for students not meeting the passing scores on the State's Basic Skills Testing Program. Dr. Cobb also revised Bulletin 741, which is the Louisiana Handbook for School Administration and served as the basis for the State's accreditation program. Dr. Cobb worked to increase in-service training for principals by coauthoring the Louisiana Academy for School Administrators Program and representing Louisiana at the Leadership Training for Principals.

After working with the Department of Education and serving as principal for schools throughout Lincoln Parish, Dr. Cobb continued his public service in the area of education by serving as superintendent for the Lincoln Parish School System. For the past 15 years, Dr. Cobb has immensely helped the 14 schools and 6,865 students in the Lincoln Parish School System. During his tenure, Dr. Cobb helped to construct the Lincoln Parish Secondary Alternative School at no cost to local taxpayers. He saw the students in Lincoln Parish receive the highest ACT scores throughout the State in 1996. In 2000, Ruston High School graduated seven National Merit Finalists, the most of any public, nonmagnet high school in the State. Dr. Cobb helped to expand the preschool program, implement the Even Start Program, construct a Parental Involvement Center, initiate the Career Options Program, wire all schools with the Internet, and implement 4x4 block scheduling in high schools.

The gifts that Dr. Cobb has given the Lincoln Parish School System and all of Louisiana go far beyond those that I have named above. Dr. Cobb has spent the past 43 years giving his kindness, his leadership, his vision, his service. It is to educators like Dr. Cobb that we owe many of the successes of our education policy. My best wishes are with Dr. Cobb and his family as he enters retirement.●

HONORING LOUIS AND LuJUANNA CARNEY

● Mr. CRAPO. Mr. President, I rise today to congratulate my good friend, Louis Carney and his wife LuJuanna. Just last week, the Carneys, who live near my family's home in Idaho Falls, celebrated their 50th wedding anniversary. I am honored to know them and pleased that I was asked to join the celebration.

I can think of no better way to commemorate their 50 years together than to mention that they are the proud parents of eight children, six who are still with us—Don, Nancy, Bob, Terry, Kevin, and Kenneth; and two who have rejoined their Heavenly Father—Laurie Ann and Jean Marie; the even prouder grandparents of fifteen; and the great grandparents of one. It speaks very highly of their commitment to each other and their family that so many of their family members were on hand to mark the occasion. Louis has been a very good friend to me over the years, and I appreciate his wisdom and guidance on many matters. He has been a strong supporter of the Boy Scouts of America program, and I share his enthusiasm for this program which can be so important in helping young men to learn new skills and achieve goals.

Louis and LuJuanna have been important members of our community. They are always available for those who are in need. They radiate happiness and contentment, and can be counted on by not only their friends, but so many others. I am proud to mark their anniversary, and even more pleased to call them friends.●

TRIBUTE TO GARY R. COOPER

● Mr. GREGG. Mr. President, I rise today to recognize and commend Gary R. Cooper upon his retirement after serving for 20 years as Executive Director of SEARCH, the National Consortium for Justice Information and Statistics.

SEARCH is a national organization dedicated to enhancing the use of information and identification technology in law enforcement. SEARCH provides invaluable no-cost technical assistance, training and support to criminal justice agencies all over the country. The organization's members are Governors appointees from each State and their common goal is to ensure that the criminal justice community has access to services that will allow them to use the best technology for communications, information sharing, and criminal identification. SEARCH has been a tremendous asset to our Nation's law enforcement and this is due in no small part to the work of Gary Cooper.

Under Gary's leadership over the past 20 years, SEARCH has truly become a leader in encouraging States to participate in national information and identification technology programs. For instance, under Gary's leadership, SEARCH made a profound contribution to the States' effective participation in the Interstate Identification Index and the National Fingerprint File, and the National Crime Information Center 2000 (NCIC 2000) program.

Through SEARCH, Gary has also helped to implement policies on the national level. While Gary has headed SEARCH, it has made a profound contribution to the development and implementation of the National Criminal Background Check System. SEARCH also played a pivotal role in the development and enactment of the Crime Identification Technology Act which today creates the legal and funding platform for the Federal /State criminal justice technology partnership. Because of Gary, SEARCH was, and is, the primary State voice in support of the successful and ongoing national adoption of the Interstate Identification Index and Privacy Compact and the development of the Compact Council.

At every important moment in the past 20-year history of criminal justice information and identification technology, Gary Cooper has been a courageous leader, an untiring champion and an insightful and influential national voice.

On the occasion of his retirement, I thank Gary R. Cooper for all that he has accomplished on behalf of criminal justice in the United States.●

HONORING HUGH BRADY

• Mr. CRAPO. Mr. President, I rise today to congratulate Mr. Hugh Brady of Boise Idaho who will be inducted into the Idaho High School Activities Hall of Fame on August 6th, 2003. In 1954 Mr. BRADY started working at Idaho Sporting Goods, and he has been dedicated to helping young people in Idaho participate in athletics ever since. Mr. BRADY, who later became the owner of the sporting goods store, has sponsored Little League baseball teams, football teams, basketball teams, soccer teams, softball teams, and bowling teams. He also took the time to coach many teams over the years.

Mr. BRADY has demonstrated extraordinary support for athletics and the youth of Idaho. There have been numerous instances when a student could not afford the cost of equipment to participate in a sport and Mr. BRADY made sure that they got it. Mr. BRADY, you make Idaho proud!

For the past 4 years, Mr. BRADY has battled lung cancer. My wife, Susan, and I along with many Idahoans will keep him in our thoughts and prayers.•

HONORING VICTIMS OF GUN VIOLENCE

• Mr. LEVIN. Mr. President, earlier this week, more than 35 dedicated cyclists with People Pedaling Peace made the 200-mile trip from Hampton, VA, to Washington, DC, to honor and remember victims of gun violence. In partnership with the Alliance for Justice, the People Pedaling Peace cyclists rode not only in honor of the victims of gun violence, but for stronger, more sensible gun safety laws in America and to raise awareness of violence against children in this country.

Pedaling for Peace was started in 2001 by Sandra and Mike McSweeney whose daughter, Stephanie, was killed while walking out of a roller rink in Hampton, VA. Mr. and Mrs. McSweeny, as well as several other individuals affected by gun violence and violence against children made the journey this year. Others who made the trip include Craig Scott, whose sister Rachel is a Columbine survivor; Amber Hensley, a student at Thurston High School in Eugene, OR, who witnessed the shootings; and Lorraine Reed, mother of two daughters, one of whom was murdered and one of whom was seriously assaulted. Unfortunately, the total number of people like them who have lost family and friends to gun violence continues to grow.

According to the Centers for Disease Control and Prevention, the total number of gun deaths in the United States has been dropping since 1993, when it peaked at nearly 40,000, to around 28,000 annually 1999 through 2001. However, guns still kill more young people in America than the most common diseases of our time. Thousands more children are injured, lose a loved one, or live in fear of gun violence.

I hope my colleagues will join me in commending all of the cyclists who pedaled for peace, and join me in supporting sensible gun safety legislation.•

DELBERT L. LATTA POST OFFICE BUILDING

• Mr. VOINOVICH. Mr. President, I rise today on behalf of a bill considered by the Senate, H.R. 985, to designate a post office in Bowling Green, OH, as the Delbert L. Latta Post Office Building. I strongly support this bill honoring a long-time member of the Ohio congressional delegation. Naming this post office after Del Latta is a fitting way to honor him. The building that houses this post office also served as a district office for Mr. Latta during his 30 years of service in Congress.

Delbert Latta is a native and lifelong resident of Ohio. Born in the small northwestern town of Weston, OH, Mr. Latta attended Findlay College and Ohio Northern University Law School.

Mr. Latta began his service to our Nation as a member of the Ohio National Guard. During World War II, Mr. Latta served with the U.S. Marine Corps Reserves.

After his military service, Mr. Latta practiced law in Bowling Green, but in 1953, he again answered the call to public service by running for the State legislature. Mr. Latta was elected to the Ohio State Senate. After serving three terms, Mr. Latta was elected by the people of Ohio's fifth congressional district to the U.S. House of Representatives. During his long and distinguished career in Congress, Mr. Latta fought hard against wasteful government spending and to balance the Federal budget, a passion that I share.

During his 30 years in Congress, Mr. Latta earned prominent committee assignments in the House, including serving as the ranking member of the Budget Committee, and as a member of the powerful Rules Committee, and the Agriculture Committee.

Naming this post office the Delbert L. Latta Post Office Building is a wonderful tribute to a man who served Ohio and our Nation with distinction throughout his life.

I thank my colleagues for their consideration of this matter.•

TRIBUTE TO ARTHUR G. STEPHENSON

• Mr. SHELBY. Mr. President, I rise today to recognize the outstanding accomplishments and distinguished career of Mr. Arthur G. Stephenson upon his retirement as the Director of the NASA Marshall Space Flight Center. It has been a privilege for me to get to know Art. While retirement announcements are things that we do not like to hear when it involves someone who has been as vital to the success of an organization as Art has been to Marshall's, I would like to say how much I have enjoyed working with Art and his staff during his tenure as the Director of the Marshall Space Flight Center.

As the Director of one of NASA's largest field installations, with more than 6,500 civil service and contract employees and an annual budget in excess of $2 billion, Art successfully managed a very broad range of activities for the U.S. space program. Some of these critical NASA initiatives included development of new reusable launch vehicles, space shuttle propulsion, advanced space transportation systems, second and third generation propulsion technology development programs, research in microgravity, and science payload operations aboard the International Space Station. He also oversaw the establishment of the National Space Science Technology Center, a partnership with universities and Federal agencies to conduct cutting-edge research. Art also oversaw the planning and establishment of the Propulsion Research Laboratory, a world-class laboratory for research into future space transportation and propulsion technology. Art has led the Marshall Center in numerous successful space shuttle launches in which Marshall was responsible for all propulsion elements. Under Art's direction, the Marshall Center has completed testing of the truss and pressurized modules for the International Space Station, and provided support for the construction and operation of the International Space Station, including Marshall's Payload Operations Center which controls all the science experiments aboard the space station.

Art brought more than 35 years of experience in the space industry to NASA and used it to the great benefit of the Marshall Center and the U.S. space program. I could list many additional achievements and professional accomplishments, and I believe that success is directly attributable to Art's record as an extraordinary leader throughout his career.

Art has been an important and respected member of the Huntsville community. I know that I speak for many people in Huntsville and everyone in the NASA family when I say that we all thank Art for his tireless commitment to NASA and to Marshall. We sincerely hope that he and his family will remain part of the Huntsville community for many years to come.•

ARTHUR LEVITT, JR.

• Mr. SARBANES. Mr. President, earlier this month the Franklin D. Roosevelt Distinguished Public Service Award was presented to Arthur Levitt, Jr., the widely respected former chairman of the Securities and Exchange Commission. The award is made annually by the Franklin D. and Eleanor Roosevelt Institute, on whose board I am privileged to serve.

The speaker at the presentation was Conrad Black, now Lord Black, chairman of the Telegraph Group, Limited. Lord Black is active in numerous nonprofit boards, foundations and councils.

In his remarks Lord Black spoke vividly and in detail about Depression-era America, and the ''bold experimentation,'' as he put it, of the New Deal years.

I ask unanimous consent that the text of Lord Black's remarks be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ADDRESS OF LORD BLACK AT FRANKLIN DELANO ROOSEVELT DISTINGUISHED PUBLIC SERVICE AWARD DINNER

On election night, 1932, unemployment stood at approximately 30%. There was minimal direct government relief for the 14 million or so unemployed. Their condition was alleviated by private sector charity, and by theft and begging.

The Soviet Union advertised in the United States for 6,000 skilled workers to go to Russia in 1932 for a period of several years; it's New York office was swamped with 100,000 applications. The natives of West Africa sent New York City $3.77 to help with relief for the poor. When the city of Birmingham, Alabama, advertised for 750 ditch-diggers to work ten-hour days for $2 per day, 12,000 applications arrived in two days.

In the coal-mining regions of Kentucky and West Virginia, over 90% of children were suffering from malnutrition. The country had suffered a general deflation of more than 20%. Millions of Americans faced the distinct possibility of death by starvation or exposure to the elements. Large numbers of people lived from the scraps and leftovers thrown out in the garbage by restaurants and hotels.

The volume of cheque transactions and of stock market transactions in the United States had declined by 60% since 1929. The amount of new capital financing had declined by over 95% since 1929. The volume of new building contracts had declined by 75%. By inauguration day in March 1933, the Dow-Jones Industrial Average was down by 90% from its high in September, 1929.

BANK FAILURES

There had been 5,000 bank failures in three years, wiping out nine million individual bank accounts. Steel production was under 20% of capacity, and United States Steel Corporation, which had had 225,000 full-time employees in 1929, now had no full-time employees, apart from those in the executive offices.

Total non-agricultural production was less than half of its 1929 level. Manufacturing income has shrunk by 65%. Agricultural production, while approximately equal in physical volume to that of 1929, had shrunk in farm income from $12 billion to slightly over $5 billion.

About 45% of the residential homes in America had been or were in danger of being foreclosed by mortgage-holders. Through the first six months of 1933, 250,000 homes were foreclosed, well over a thousand per day, the families pitched out into the streets. The money supply, deflation-adjusted, had declined by 25% in four years.

Many local and state governments, including Chicago and Georgia, could not pay their schoolteachers. Georgia closed over a thousand schools attended by 170,000 students. Most rural Alabama white schools were closed through the early months of 1933.

On the day before inauguration day, 32 states had closed all their banks indefinitely. Six other states had closed almost all their banks. In the other ten states and in the District of Columbia, withdrawals were limited to 5% of deposits and in Texas to $10 per day. The U.S. financial system had reached the last extremity before it would collapse completely, taking the life's savings of tens of millions of people and what was left of the international economic system with it.

American literature achieved a virtual golden age with writers such as John Steinbeck, Erskine Caldwell, Edmund Wilson, and John Dos Passos describing depression conditions.

FRANKLIN D. ROOSEVELT'S FIRST INAUGURAL ADDRESS

Over 400,000 people came out to hear Franklin D. Roosevelt's famous first inaugural address; they covered 40 acres of lawns adjacent to the Capitol. For the first time since the Civil War, soldiers in full combat gear and machine gun emplacements surrounded by sand-bags were visibly guarding the main public buildings of Washington.

Roosevelt promised bold experimentation. In the Hundred Days of the spring of 1933, the Roosevelt administration reorganized and reopened the banks and guaranteed their deposits, a great monetary step as bank deposits now joined most definitions of the money supply.

The legislation of the Hundred Days incentivized price and wage increases, reduced the working week, cut government salaries, increased some marginal taxes, tolerated a degree of cartelism to raise prices and avoid over-production, encouraged collective bargaining, and engaged in massive workfare schemes that employed nearly half the unemployed in projects of conservation and public works. In the first year of these programs, 500,000 miles of roads and 40,000 schools, 3,500 parks and 1,000 airfields were built or upgraded. The Civilian Conservation Corps, through the 'thirties, thinned four million acres of trees, stocked one billion fish, and built 30,000 animal shelters.

Ordinary unemployment declined by four million through 1933, partly due to the reduction in the work week. Farmers voted by category to approve production cutbacks, permitting farm price increases, and some of the agricultural surplus was taken for distribution to the needy. The Tennessee Valley Authority was launched and great progress began on rural electrification, flood control, and drought control.

The Hundred Days also refinanced the nation's mortgages, effectively departed the gold standard, exchanged embassies with the Soviet Union, and repealed Prohibition.

THE SECOND NEW DEAL

The second New Deal, in 1934 and 1935, was built around Social Security and included the Labour Relations Act, the Securities and Exchange Commission, a comprehensive modernization of the Federal Reserve, and what was called, but was not really, a Wealth Tax. It outraged William Randolph Hearst and stole the thunder of Huey Long and other radicals, as it was designed to do.

After a pause, when unemployment again began to rise, Roosevelt brought in the third New Deal in 1938 with the Fair Labor Standards Act and massive public works and conservation employment schemes. These were successful and reduced unemployment in mid-1939 to about 8%, less than two points above where it stands today, if the public sector relief workers are considered to be employed people.

Thereafter, like other countries, the United States relied on rearmament and the selective service to reduce unemployment, which fell by up to 500,000 per month coming up to the 1940 election, and had almost vanished before the entry of the United States into the war in 1941.

THE GI BILL OF RIGHTS

Finally, came the GI Bill of Rights, which greatly subsidized the education, and home and farm and business ownership of veterans. In the late 'forties, nearly half the male university students of the United States were beneficiaries of that act and the barriers to advancement for working class families were largely removed.

I yield to few people in my enthusiasm for the capitalist system, but we must all remember that in 1933, capitalism in America had failed, and the political system was in danger of failing with it.

Roosevelt developed a refrain in his later elections that served him well and was unanswerable. It want: ''You are, most of you, old enough to remember what things were like in 1933.

''You remember the closed banks and the breadlines and the starvation wages; the foreclosures of homes and farms, and the bankruptcies of business; the 'Hoovervilles,' and the young men and women of the Nation facing a hopeless, jobless, future; the closed factories and mines and mills; the ruined and abandoned farms; the stalled railroads and the empty docks; the blank despair of a whole Nation, and the utter impotence of the Federal Government.''

The voters did remember, as people remember a horrible nightmare; but it had not been a dream; it was the United States in 1933.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the Unite States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 11:59 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, without amendment.

S. 858. An act to extend the Abraham Lincoln Bicentennial Commission, and for other purposes.

The message also announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1511. AN act to award a congressional gold medal to Prime Minister Tony Blair.

H.R. 2474. An act to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal year 2003 and 2004.

H.J. Res. 49. A joint resolution recognizing the important service to the Nation provided by the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary.

The message further announced that the House had agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 49. Concurrent resolution expressing the sense of the Congress that the

sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences.

At 6:19 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2559. An act making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

At 7:50 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 531. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP).

MEASURES REFERRED

The following bill and joint resolution were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1511. An act to award a congressional gold medal to Prime Minister Tony Blair; to the Committee on Banking, Housing, and Urban Affairs.

H.J. Res. 49. Joint resolution recognizing the important service to the Nation provided by the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary; to the Committee on Agriculture, Nutrition, and Forestry.

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 49. Concurrent resolution expressing the sense of the Congress that the sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences; to the Committee on Foreign Relations.

MEASURES PLACED ON THE CALENDAR

The following bills were read the first and second times by unanimous consent, and placed on the calendar:

H.R. 2559. An act making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

H.R. 531. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP).

MEASURES READ THE FIRST TIME

The following bill was read the first time:

S. 11. A bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2961. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Amendment to Class E Airspace: Windsor Locks, Bradley International Airport, CT'' ((RIN2120–AA66)(2003–0100)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2962. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''IFR Altitudes; Miscellaneous Amendments (13)'' ((RIN2120–AA63)(2003–0002)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2963. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''IFR Altitudes: Miscellaneous Amendments (60)'' ((RIN2120–AA63)(2003–0003)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2964. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Airbus Model A319 131, 132, and 133; A320, 232, and 233, and A321 231 Series Airplanes; Equipped with International Aero Engines V2500 A5 Series Engines'' ((RIN2120–AA64)(2003–0250)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2965. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Dassault Model Mystere-Falcon 50 Series Airplanes'' ((RIN2120–AA64)(2003–0249)) received on June 19 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–2966. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Raytheon Aircraft Company Model 390 Airplanes'' ((RIN2120–AA64)(2003–0248)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2967. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: CFM International CFM56 Series Turbofan Engines'' ((RIN2120–AA64)(2003–0247)) received on June 19 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–2968. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Dornier Weke CmbH Model DO 27Q–6 Airplanes'' ((RIN2120–AA64)(2003–0246)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2969. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Dowty Aerospace Propellers, Models R354, R375, R389, and R390 Propellers'' ((RIN2120–AA64)(2003–0239)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2970. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Hartzell Propeller Inc. Model HC B3TN 5 Propellers'' ((RIN2120–AA64)(2003–0238)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2971. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Hartzell Propeller Inc. Model HD E6C 3B/E13890'' ((RIN2120–AA64)(2003–0237)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2972. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Bombardier Model C1 600 2C10 Series Airplanes'' ((RIN2120–AA64)(2003–0236)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2973. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Raytheon Aircraft Company Model 1900D Airplanes'' ((RIN2120–AA64)(2003–0235)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2974. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Bell Helicopter Textron Canada Model 427 Helicopters'' ((RIN2120–AA64)(2003–0234)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2975. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Fokker Model F 28 Mark 1000, 2000, 3000, and 4000 Series Airplanes'' ((RIN2120–AA64)(2003–0233)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2976. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Eurocopter France Model SA341G and SA342IJ Helicopters'' ((RIN2120–AA64)(2003–0232)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2977. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Bell Helicopter Textron Canada Limited Model 427 Helicopters'' ((RIN2120–AA64)(2003–0231)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2978. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Agusta SpA Model A109E Helicopters'' ((RIN2120–AA64)(2003–0230)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2979. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule

entitled ''Airworthiness Directives: Sikorsky Aircraft Corp Model S76A, B, and C Helicopters'' ((RIN2120–AA64)(2003–0229)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2980. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: McDonnell Douglas Model MD 90 30 Airplanes'' ((RIN2120–AA64)(2003–0228)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2981. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Bombardier Model CL 600 2B19 Series Airplanes'' ((RIN2120–AA64)(2003–0227)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2982. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: McDonnell Douglas Model 717–200 Airplanes'' ((RIN2120–AA64)(2003–0226)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2983. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Schweizer Aircraft Corporation Model 269D Helicopters'' ((RIN2120–AA64)(2003–0225)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2984. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: McDonnell Douglas Model DC 9 10, 20, 30, 40, and 50 Series Airplanes; and DC 9 81, 82, 83, 87, and MD 88 Airplanes'' ((RIN2120–AA64)(2003–0224)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2985. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Cessna Aircraft Company Models 441 and F406 Airplanes'' ((RIN2120–AA64)(2003–0223)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2986. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Rolls Royce Deutschland Ltd and Co KG Models BR700 710 A10 and BR700 710 A2 20 Turbofan Engines'' ((RIN2120–AA64)(2003–0222)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2987. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Rolls Royce Deutschland Ltd and Co KG Models BR700 710 A1 10 and BR700 710 A2 20 Turbofan Engines'' ((RIN2120–AA64)(2003–0221)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2988. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Rolls Royce Corporation 501–D Series Turboprop Engines'' ((RIN2120–AA64)(2003–0220)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2989. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Boeing Model 747–200B and 200F Series Airplanes Powered by Pratt and Whitney JT9D–70 Series Engines'' ((RIN2120–AA64)(2003–0219)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2990. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Raytheon Model DH 125, HS 125, and BH 125 Series Airplanes; Model BAe 125 Series 800A, 800A (C–29A), 800A (U–125), 800B, 1000A, and 1000B Airplanes; and Models Hawker 800, 800 (including variant U–125A), and 1000, and 8000 XP Airplanes'' ((RIN2120–AA64)(2003–0218)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2991. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Raytheon Aircraft Company Beech Models 1900, 1900C, and 1900D Airplanes'' ((RIN2120–AA64)(2003–0217)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2992. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Ridgely, MD'' ((RIN2120–AA66)(2003–0109)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2993. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class D Airspace; and Modification of Class E Airspace; Topeka Philip Billard Unicipa; Airport, KS'' ((RIN2120–AA66)(2003–0108)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2994. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class E Airspace; Clinton, IA'' ((RIN2120–AA66)(2003–0107)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2995. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class E Airspace; Davenport, IA'' ((RIN2120–AA66)(2003–0106)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2996. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class E Airspace; Independence, IA'' ((RIN2120–AA66)(2003–0105)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2997. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class E Airspace; Muskegon, MI'' ((RIN2120–AA66)(2003–0104)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2998. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class E Airspace; Eureka, KS'' ((RIN2120–AA66)(2003–0103)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2999. A communication from the Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Implementation of the Understandings Reached at the June 2002 Australia Group (AG) Meeting and the AG Intersessional Decision on Cross Flow Filtration Equipment—Chemical and Biological Weapons Controls in the Export Administration Regulations'' (RIN0694–AC70) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3000. A communication from the Secretary, Office of the General Counsel, Federal Trade Commission, transmitting, pursuant to law, the report of a rule entitled ''Privacy Act System Notice for the National Do Not Call Registry System'' received on June 24 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–3001. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Closure of the Third Season Apportionment of Directed Fishing for Yellowfin Sole by Vessels Using Trawl Gear in the Bering Sea and Aleutian Islands Management Area (BSAI)'' received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3002. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries Off West Coast States and in the Western Pacific; Pacific Coast Groundfishery; Annual Specifications and Management Measures; Trip Limit Adjustments'' received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3003. A communication from the Counsel, National Institute of Standards and Technology, Department of Commerce, transmitting , pursuant to law, the report of a rule entitled ''Procedures for Implementation of the National Construction Safety Team Act'' (RIN0693–AB52) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3004. A communication from the Counsel, National Institute of Standards and Technology, Department of Commerce, transmitting , pursuant to law, the report of a rule entitled ''Procedures for Implementation of the National Construction Safety Team Act'' (RIN0693–AB52) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3005. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Northeastern United States; Atlantic Mackerel, Squid and Butterfish Fisheries; Framework Adjustment 3'' (RIN0648–AQ57) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3006. A communication from the Assistant Administrator for Fisheries, National Oceanic and Atmospheric Administration, Department of Commerce, transmitting, pursuant to law, the 1999 Annual Report regarding the administration of the Marine Mammal Protection Act of 1972; to the Committee on Commerce, Science, and Transportation.

EC–3007. A communication from the Chairman, Federal Communications Commission, transmitting, pursuant to law, a report relative to 700 MHz auctions, digital television,

and mobile communications services; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. WARNER, from the Committee on Armed Services, with amendments:

S. 1025. An original bill to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes (Rept. No. 108–80).

By Mr. SPECTER, from the Committee on Appropriations, without amendment:

S. 1356. An original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes (Rept. No. 108–81).

By Mrs. HUTCHISON, from the Committee on Appropriations, without amendment:

S. 1357. An original bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes (Rept. No. 108–82).

By Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, without amendment:

S. 888. A bill to reauthorize the Museum and Library Services Act, and for other purposes (Rept. No. 108–83).

By Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, with an amendment:

S. 650. A bill to amend the Federal Food, Drug, and Cosmetic Act to authorize the Food and Drug Administration to require certain research into drugs used in pediatric patients (Rept. No. 108–84).

By Mr. LUGAR, from the Committee on Foreign Relations, without amendment and with a preamble:

S. Res. 62. A resolution calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

By Mr. LOTT, from the Committee on Rules and Administration, without amendment:

S. Res. 138. A resolution to amend rule XXII of the Standing Rules of the Senate relating to the consideration of nominations requiring the advice and consent of the Senate.

By Mr. LUGAR, from the Committee on Foreign Relations, without amendment and with an amended preamble:

S. Res. 149. A resolution expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate.

By Mr. HATCH, from the Committee on the Judiciary, without amendment and with a preamble:

S. Res. 174. A resolution designating Thursday, November 20, 2003, as ''Feed America Thursday''.

S. Res. 175. A resolution designating the month of October 2003, as ''Family History Month''.

By Mr. LOTT, from the Committee on Rules and Administration, without amendment:

S. Res. 178. A resolution to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate wing of the Capitol and Senate office buildings for personal use.

S. 148. A bill to provide for the Secretary of Homeland Security to be included in the line of Presidential succession.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. WARNER for the Committee on Armed Services.

Army nomination of Lt. Gen. John P. Abizaid.

Army nominations beginning Brigadier General George A. Alexander and ending Colonel Matthew J. Whittington, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Col. William J. Germann.

Army nomination of Col. William M. Jacobs.

Marine Corps nominations beginning Brig. Gen. John W. Bergman and ending Brig. Gen. John J. McCarthy, Jr., which nominations were received by the Senate and appeared in the Congressional Record on April 2, 2003.

Air Force nomination of Col. Thomas F. Deppe.

Navy nomination of Adm. William J. Fallon.

Air Force nomination of Maj. Gen. Michael M. Dunn.

Army nomination of Maj. Gen. Keith B. Alexander.

Marine Corps nomination of Lt. Gen. Wallace C. Gregson, Jr.

Navy nomination of Capt. Terry L. McCreary.

Navy nominations beginning Capt. Martin J. Brown and ending Capt. Michael J. Lyden, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Captain John M. Bird and ending Captain Peter J. Williams, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Air Force nomination of Gen. Robert H. Foglesong.

Air Force nomination of Maj. Gen. Daniel P. Leaf.

Air Force nomination of Brig. Gen. Joseph E. Kelley.

Air Force nomination of Brig. Gen. Douglas Burnett.

Air Force nomination of Col. Craig S. Ferguson.

Navy nomination of Vice Adm. Michael G. Mullen.

Air Force nomination of Lt. Gen. William T. Hobbins.

Air Force nomination of Maj. Gen. Randall M. Schmidt.

Air Force nomination of Maj. Gen. Walter E. L. Buchanan III.

Army nomination of Lt. Gen. Dan K. McNeill.

Army nomination of Maj. Gen. William G. Boykin.

Marine Corps nomination of Maj. Gen. Robert R. Blackman, Jr.

Mr. WARNER. Mr. President, for the Committee on Armed Services I report favorably the following nomination list which was printed in the RECORD on the date indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that this nomination lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Army nomination of Kenneth S. Azarow.

Air Force nominations beginning Rebecca G. Abraham and ending Jeffrey Yuen, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning Brian J. Acker and ending Angela D. Washington, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning Paul M. Barzler and ending Charles W. Williamson III, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nomination of James R. Burkhart.

Air Force nominations beginning Charles M. Belisle and ending Brett A. Wyrick, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Air Force nominations beginning Glenn D. Addison and ending Daniel J. Zachman, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Air Force nomination of Thomas K. Hunter, Jr.

Air Force nomination of Jeffrey J. King.

Air Force nominations beginning Jean B. Dorval and ending Gary M. Walker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Richard J. Delorenzo, Jr.

Air Force nomination of Gerald M. Schneider.

Air Force nomination of Jane B. Taylor.

Air Force nominations beginning Darrell A. Jesse and ending Norbert S. Walker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nominations beginning Thomas C. Barnett and ending Jean A. Vargo, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Edward C. Callaway.

Air Force nomination of H. Michael Tennerman.

Air Force nomination of Steven E. Ritter.

Air Force nomination of Bryan A. Keeling.

Air Force nomination of Robert L. Zabel, Jr.

Air Force nominations beginning Darryl G. Elrod, Jr. and ending Kevin R. Vanvalkenburg, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Drew Y. Johnston, Jr.

Air Force nomination of Rachel L. Beck.

Air Force nomination of Larry J. Mastin.

Air Force nominations beginning Robert L. Daugherty, Jr. and ending Charles V. Rath, Jr., which nominations were received by the Senate and appeared in the Congressional Record on June 16, 2003.

Army nominations beginning Craig M Anderson and ending Diane M Zierhoffer, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nominations beginning Anuli L Anyachebelu and ending Donald G Zugner, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nominations beginning Doreen M Agin and ending Bonnita D Wilson, which

nominations were received by the Senate and appeared in the Congressional Record on January 1.

Army nominations beginning Kevin R Armstrong and ending Nancy A Vincentjohnson, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nomination of James A. Decamp.

Army nomination of Timothy H. Sughrue.

Army nominations beginning Leslie J. Mitkos, Jr. and ending Berris D. Samples, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Army nominations beginning Patricia J. Mcdaniel and ending Nicholas K. Stravelakis, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Army nomination of Scott D. Kothenbeutel.

Army nomination of Glenn T. Bessinger.

Army nominations beginning Jane M. Anderholt and ending Jay A. Whitaker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Army nominations beginning Rodney A. Armon and ending Mark W. Thackston, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Army nomination of Anthony Sullivan.

Army nomination of Bryan C. Sleigh.

Army nomination of Michael F. McDonough.

Navy nomination of Michael U. Rump.

Navy nominations beginning William A. Davies and ending Gary S. Tollerene, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Douglas W. Fenske and ending Michael J. Kautz, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Brian H. Miller and ending Perry T. Tuey, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Gerald W. Clusen and ending Mark A. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Kenneth J. Braithwaite and ending Andrew H. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Christopher M. Ballister and ending Carl M. M. Lee, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Jeffrey D. Adamson and ending Marcus K. Neeson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Danford S. K. Afong and ending Theodore A. Wyka, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Scott F. Bohnenkamp and ending Christopher L. Wall, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Charles L. Collins and ending Cynthia R. Sugimoto, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Gregory S. Adams and ending Peter A. Withers, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Bradford E. Ableson and ending Olric R. Wilkins, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Christopher A. Barnes and ending Scott M. Stanley, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Thomas M. Balestrieri and ending Robert S. Wright, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Lisa L. Arnold and ending Peggy W. Williams, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Scott W. Bailey and ending Kevin R. Wheelock, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Matthew R. Beebe and ending Steven M. Wirsching, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Evan A. Applequist and ending Richard D. Wright, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning William B. Adams and ending Daniel J. Zinder, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Rebecca E. Brenton and ending Warren C., Graham III, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Kathy A. Baran and ending Margaret A. Taylor, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Michael D. Disano and ending Vincent M. Scott, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Nancy R. Dillard and ending Christopher L. Vance, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Jean E. Benfer and ending Cynthia L. Widick, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning David L. Bailey and ending Russell L. Shaffer, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Robert W. Archer and ending Jim O. Romano, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Christopher L. Abbott and ending William A., Wright III, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Charles S. Anderson and ending Philip A. Yates, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Brian K. Antonio and ending Thomas L. Vanpetten, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Eugene M. Abler and ending Michael E. Zamesnik, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nomination of Judy L. Miller.

Navy nominations beginning Thomas W. Harrington and ending Robert L. Young, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Matthew O. Foley III and ending Frank G. Usseglio II, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Craig E. Bundy and ending Cliff P. Watkins, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning William M. Arbaugh and ending Richard E. Wolfe, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Daniel M. Bleskey and ending William E. Vaughan, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Bartley G. Cilento, Jr. and ending James L. White, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Nancy J. Bates and ending Lloyd G. Wingfield, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Annemarie Adamowicz and ending Mary A. White, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Sherry L. Breland and ending Julia D. Worcester, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Navy nominations beginning Raul D. Bantog and ending Donna M. Willoughby, which nominations were received by the Senate and appeared in the Congressional Record on June 16, 2003.

Navy nominations beginning Linsly G. M. Brown and ending Denise M. Shorey, which nominations were received by the Senate and appeared in the Congressional Record on June 18, 2003.

By Mr. LUGAR for the Committee on Foreign Relations.

*Marsha E. Barnes, of Maryland, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Suriname.

The following is a list of all members of my immediate family and their spouses. I ahve asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Marsha E. Barnes

Post: Paramaribo, Suriname.

Contributions, amount, date, and donee:

1. Self, none.

2. Spouse, none.

3. No children.
4. Parents deceased.
5. Grandparents deceased.
6. Brother and spouse: Malcolm Samuel John Barnes and Shirley Barnes, none.
7. No sisters.

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*Robert W. Fitts, of New Hampshire, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Papua New Guinea, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to the Solomon Islands and Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Vanuatu.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Robert W. Fitts.

Post: U.S. Ambassador—Papua New Guinea.

Contributions, amount, date, and donee:
1. Self, N/A.
2. Spouse, N/A.
3. Children and spouses: none.
4. Parents: N/A.
5. Grandparents: N/A.
6. Brothers and spouses: Gary Allen Fitts, $100, 2000, Nat Goldharber (VP); James Andrew Fitts, $50, 2002, Craig Benson (NH Gov).
7. Sisters and Spouses, none.

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*John E. Herbst, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Ukraine.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: John E. Herbst.

Post: Ukraine.

Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, none.
3. Children and spouses: Maria Herbst, Ksenia Herbst, Aleksandra Herbst, Nicholas Herbst, John Herbst, none.
4. Parents: Christopher Herbst, deceased; Mary Herbst, deceased.
5. Grandparents: John Herbst and Sadie Herbst, deceased; Egidio Vaccheli and Irene Vaccheli, deceased.
6. Brothers and spouses: none.
7. Sisters and spouses: Christine Herbst, none; Mitchell Stern, none.

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*William B. Wood, of New York, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Colombia.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: William B. Wood.

Post: Ambassador to Colombia.

Contributions, amount, date, and donee:
1. Self, none.
2. Spouse: Never married.
3. Children and spouses: No children.
4. Parents: Both deceased more than 20 years.
5. Grandparents: Deceased more than 20 years.
6. Brothers and spouses: Peter R. Wood, not married.
7. Sisters and spouses: No sisters.

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*Tracey Ann Jacobson, of the District of Columbia, a Foreign Service Officer of Class One, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Turkmenistan.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee Tracey Ann Jacobson.

Post: COM, Ashgabat, Turkmenistan.

Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, Lars Johansson, none.
3. Children and spouses: stepdaughter, Emmelie Johansson, none.
4. Parents: Winifred B. Thomas and John C. Thomas, none.
5. Grandparents, none.
6. Brothers and spouses, none.
7. Sisters and spouses: Teri and Terry Dermody, none.

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*George A. Krol, of New Jersey, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Belarus.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: George Albert Krol.

Post: Minsk, Belarus.

Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, none.
3. Children and spouses, none.
4. Parents, Anthony and Ann Krol, none.
5. Grandparents, deceased.
6. Brothers: David Krol, none; Anthony Krol, none, Alice Milrod (spouse), none.
7. Sisters, none.

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*Greta N. Morris, of California, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of the Marshall Islands.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Greta N. Morris.

Post: Majuro.

Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, Charles H. Morris, deceased, none.
3.Children and spouses, none.
4. Parents: Gretchen W. Nance, Kendall W. Nance, both deceased, none.
5. Grandparents: Willis and Augusta Wiesmore, James Flemming and Frances Nance, none.
6. Brothers and spouses, N/A.
7. Sisters and spouses, Ernestine D. Nance, none.

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*John F. Maisto, of Pennsylvania, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee John Francis Maisto.

Post Permanent Representative of the U.S. to the Organization of American States.

Contributions, amount, date, and donee:
1. Self, John F. Maisto, none.
2. Spouse, Maria Consuelo G. Maisto, none.
3. Children and spouses: John J. Maisto and Karen Nelson, none; Maria C. Maisto and Edward Lynch, none; M. Cristina Maisto, none.
4. Parents: John Maisto, deceased; Mary P. Maisto, none.
5. Grandparents: Elpedio and Luisa Maisto, Petronilla and Luigi Tomaino, all deceased.
6. Brothers and spouses, Alberto L. and Mary Jean Maisto, none.
7. Sisters and spouses, N/A.

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*Roger Francisco Noriega, of Kansas, to be an Assistant Secretary of State (Western Hemisphere Affairs).

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Roger F. Noriega.

Post: Assistant Secretary of State for Western Hemisphere Affairs.

Contributions, amount, date, and donee:
1. Self, $250, 10/10/95, Bob Dole for President.
2. Spouse, N/A.
3. Children and spouses: N/A.
4. Parents names: Richard Noriega, and Lucille Noriega, none.
5. Grandparents: all deceased, none.
6. Brothers and spouses names: James P. Noriega, and Carolos R. Noriega, both deceased.
7. Sisters and spouses names: Rita and Michael Prahm, none; Rosalie and Douglas Jackson, none; Emilie Palmer, divorced, none.

Mr. LUGAR. Mr. President, for the Committee on Foreign Relations I report favorably the following nomination lists which were printed in the RECORDS on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Foreign Service nominations beginning Ali Abdi and ending Lawrence C. Mandel, which nominations were received by the Senate and appeared in the Congressional Record on May 22, 2003.

Foreign Service nominations beginning Beth A. Salamanca and ending Peter H. Chase, which nominations were received by the Senate and appeared in the Congressional Record on June 3, 2003.

By Ms. COLLINS for the Committee on Governmental Affairs.

Fern Flanagan Saddler, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

*Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.

Judith Nan Macaluso, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

By Mr. CAMPBELL for the Committee on Indian Affairs.

*John Richard Grimes, of Massachusetts, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring May 19, 2006.

*Lisa Genevieve Nason, of Alaska, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring October 18, 2004.

*Georgianna E. Ignace, of Wisconsin, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring October 18, 2004.

*Charles W. Grim, of Oklahoma, to be Director of the Indian Health Service, Department of Health and Human Services, for a term of four years.

By Mr. HATCH for the Committee on the Judiciary.

Thomas M. Hardiman, of Pennsylvania, to be United States District Judge for the Western District of Pennsylvania.

Diane M. Stuart, of Utah, to be Director of the Violence Against Women Office, Department of Justice.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. ENSIGN (for himself, Mr. FRIST, Mr. MCCONNELL, Mr. KYL, Mr. BUNNING, Mr. ENZI, Mr. THOMAS, Mr. VOINOVICH, Mr. HAGEL, Mr. CORNYN, and Mr. INHOFE):

S. 11. A bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

By Mr. LEVIN:

S. 1338. A bill to decrease the matching funds requirement and authorize additional appropriations for Keweenaw National Historical Park in the State of Michigan; to the Committee on Energy and Natural Resources.

By Mr. BREAUX (for himself and Mr. ROBERTS):

S. 1339. A bill to amend title 5, United States Code, to provide for appropriate overtime pay for National Weather Service employees who perform essential services during severe weather events; to the Committee on Governmental Affairs.

By Mr. GRAHAM of Florida (for himself and Mr. NELSON of Florida):

S. 1340. A bill to authorize additional judgeships in the middle and southern districts of Florida, and for other purposes; to the Committee on the Judiciary.

By Mrs. HUTCHISON (for herself and Mr. CORNYN):

S. 1341. A bill to name the Department of Veterans Affairs in Houston, Texas, as the ''Michael E. DeBakey Department of Veterans Affairs Medical Center''; to the Committee on Veterans' Affairs.

By Mrs. FEINSTEIN:

S. 1342. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Indian Affairs.

By Mr. EDWARDS:

S. 1343. A bill to amend title 11, United States Code, to provide for the avoidance of certain transfers, and the alternative prosecution of certain actions, relating to certain retirement benefits; to the Committee on the Judiciary.

By Mr. CORZINE (for himself, Mr. SCHUMER, Mr. AKAKA, and Mrs. BOXER):

S. 1344. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mrs. MURRAY (for herself, Mrs. BOXER, Ms. CANTWELL, Mrs. CLINTON, Mr. CORZINE, Mr. EDWARDS, Mrs. FEINSTEIN, Mr. KENNEDY, Mr. LAUTENBERG, Mr. SCHUMER, and Mr. HOLLINGS):

S. 1345. A bill to extend the authorization for the ferry boat discretionary program, and for other purposes; to the Committee on Environment and Public Works.

By Ms. CANTWELL (for herself and Ms. COLLINS):

S. 1346. A bill to amend the Workforce Investment Act of 1998 to provide for strategic sectoral skills gap assessments, strategic skills gap action plans, and strategic training capacity enhancement seed grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1347. A bill to amend the Workforce Investment Act of 1998 to provide for training service and delivery innovation projects; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1348. A bill to amend the Higher Education Act of 1965 to modify the computation of eligibility for certain Federal Pell Grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SMITH (for himself, Mr. KOHL, Mrs. BOXER, Mr. CORNYN, Mr. FEINGOLD, Mrs. HUTCHISON, Ms. MURKOWSKI, and Mr. WYDEN):

S. 1349. A bill to amend the Internal Revenue Code of 1986 with respect to the eligibility of veterans for mortgage bond financing, and for other purposes; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1350. A bill to require Federal agencies, and persons engaged in interstate commerce, in possession of electronic data containing personal information, to disclose any unauthorized acquisition of such information; to the Committee on the Judiciary .

By Mr. FRIST:

S. 1351. A bill to amend the Tennessee Valley Authority Act of 1933 to modify provisions relating to the Board of Directors of the Tennessee Valley Authority, and for other purposes; to the Committee on Environment and Public Works.

By Mr. WYDEN (for himself and Mrs. FEINSTEIN):

S. 1352. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. BROWNBACK (for himself and Mr. DEWINE):

S. 1353. A bill to establish new special immigrant categories; to the Committee on the Judiciary.

By Ms. MURKOWSKI (for herself and Mr. STEVENS):

S. 1354. A bill to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SMITH (for himself and Mr. WYDEN):

S. 1355. A bill to authorize the Bureau of Reclamation to participate in the rehabilitation of the Wallowa Lake Dam in Oregon, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SPECTER:

S. 1356. An original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mrs. HUTCHISON:

S. 1357. An original bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mr. AKAKA (for himself, Mr. GRASSLEY, Mr. LEVIN, Mr. LEAHY, and Mr. DURBIN):

S. 1358. A bill to amend chapter 23 of title 5, United States Code, to clarify the disclosure of information protected from prohibited personnel practices, require a statement in non-disclosure policies, forms, and agreements that such policies, forms, and agreements conform with certain disclosure protections, provide certain authority for the Special Counsel, and for other purposes; to the Committee on Governmental Affairs.

By Mrs. BOXER:

S. 1359. A bill to allow credit unions to provide international money transfer services and to require disclosures in connection with international money transfers from all money transmitting service providers; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. GRAHAM of Florida:

S. 1360. A bill to amend section 7105 of title 38, United States Code, to clarify the requirements for notices of disagreement for appellate review of Department of Veterans Affairs activities; to the Committee on Veterans' Affairs.

By Mr. SMITH:

S. 1361. A bill to amend the Internal Revenue Code of 1986 to provide that foreign base company shipping income shall include only income from aircraft and income from certain vessels transporting petroleum and related products; to the Committee on Finance.

By Mrs. BOXER:

S. 1362. A bill to authorize the Port Passenger Accelerated Service System (Port PASS) as a permanent program for land border inspection under the Immigration and Nationality Act, and for other purposes; to the Committee on the Judiciary.

By Mr. REID:

S. 1363. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service; to the Committee on Energy and Natural Resources.

By Ms. MURKOWSKI:

S. 1364. A bill to amend the Alaska National Interest Lands Conservation Act to authorize the payment of expenses after the death of certain Federal employees in the State of Alaska; to the Committee on Energy and Natural Resources.

By Mr. McCONNELL (for himself, Mr. KYL, and Mr. LEAHY):

S. 1365. A bill to provide increased foreign assistance for Cambodia under certain circumstances, and for other purposes; to the Committee on Foreign Relations.

By Mr. ALLARD (for himself, Mr. FEINGOLD, and Mr. CRAPO):

S. 1366. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Environment and Public Works.

By Mr. McCONNELL (for himself, Mr. BAYH, and Mr. FITZGERALD):

S. 1367. A bill to amend the Richard B. Russell National School Lunch Act to establish programs to promote increased consumption of milk in schools and to improve the nutrition and health of children; to the Committee on Agriculture, Nutrition, and Forestry.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LUGAR (for himself, Mr. SARBANES, and Mr. FEINGOLD):

S. Res. 187. A resolution expressing the sense of the Senate regarding the centenary of the Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation.

By Mr. CHAMBLISS (for himself and Mr. MILLER):

S. Res. 188. A resolution honoring Maynard Holbrook Jackson, Jr. former Mayor of the City of Atlanta, and extending the condolences of the Senate on his death.

By Mr. FRIST (for himself and Mr. DASCHLE):

S. Res. 189. A resolution electing Doctor Barry C. Black, of Baltimore, Maryland, as Chaplain of the United States Senate.

By Mr. AKAKA (for himself, Mr. INHOFE, Mr. WARNER, Mr. LEVIN, Mrs. MURRAY, Mr. DODD, Ms. LANDRIEU, Mr. PRYOR, Mr. DASCHLE, Mr. BIDEN, Mr. KENNEDY, Mr. FEINGOLD, Mr. DURBIN, Mr. NELSON of Nebraska, Mr. NELSON of Florida, Mr. REED, Mr. CHAMBLISS, Ms. CANTWELL, Mr. SARBANES, Mrs. CLINTON, Mr. ROBERTS, Mr. LAUTENBERG, Mr. LIEBERMAN, Mr. DAYTON, Ms. MURKOWSKI, Mr. INOUYE, Mr. HAGEL, Ms. COLLINS, and Mr. STEVENS):

S. Res. 190. A resolution commending General Eric Shinseki of the United States Army for his outstanding service and commitment to excellence.

By Mr. CORZINE (for himself, Mr. WARNER, Mr. LAUTENBERG, and Mrs. CLINTON):

S. Con. Res. 56. A concurrent resolution expressing the sense of the Congress that a commemorative postage stamp should be issued honoring Gunnery Sergeant John Basilone, a great American hero; to the Committee on Governmental Affairs.

By Ms. LANDRIEU:

S. Con. Res. 57. A concurrent resolution honoring Dr. Norman Christopher Francis, president of Xavier University of Louisiana, for his longstanding dedication and service specific to Xavier University and to education as a whole; to the Committee on Health, Education, Labor, and Pensions.

ADDITIONAL COSPONSORS

S. 56

At the request of Mr. JOHNSON, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 56, a bill to restore health care coverage to retired members of the uniformed services.

S. 392

At the request of Mr. REID, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 392, a bill to amend title 10, United States Code, to permit retired members of the Armed Forces who have a service-connected disability to receive both military retired pay by reason of their years of military service and disability compensation from the Department of Veterans Affairs for their disability.

S. 478

At the request of Mr. SARBANES, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 478, a bill to grant a Federal charter Korean War Veterans Association, Incorporated, and for other purposes.

S. 491

At the request of Mr. REID, the names of the Senator from Rhode Island (Mr. CHAFEE) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 491, a bill to expand research regarding inflammatory bowel disease, and for other purposes.

S. 596

At the request of Mr. ENSIGN, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 596, a bill to amend the Internal Revenue Code of 1986 to encourage the investment of foreign earnings within the United States for productive business investments and job creation.

S. 611

At the request of Mr. CRAIG, his name was added as a cosponsor of S. 611, a bill to amend the Internal Revenue Code of 1986 to treat gold, silver, and platinum, in either coin or bar form, in the same manner as stocks and bonds for purposes of the maximum capital gains rate for individuals.

S. 623

At the request of Mr. WARNER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 623, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 640

At the request of Mr. LEAHY, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 640, a bill to amend subchapter III of chapter 83 and chapter 84 of title 5, United States Code, to include Federal prosecutors within the definition of a law enforcement officer, and for other purposes.

S. 684

At the request of Mr. SMITH, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 684, a bill to create an office within the Department of Justice to undertake certain specific steps to ensure that all American citizens harmed by terrorism overseas receive equal treatment by the United States Government regardless of the terrorists' country of origin or residence, and to ensure that all terrorists involved in such attacks are pursued, prosecuted, and punished with equal vigor, regardless of the terrorists' country of origin or residence.

S. 777

At the request of Mr. INHOFE, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 777, a bill to amend the impact aid program under the Elementary and Secondary Education Act of 1965 to improve the delivery of payments under the program to local educational agencies.

S. 835

At the request of Ms. LANDRIEU, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 835, a bill to amend the Higher Education Act of 1965 to provide student loan borrowers with a choice of lender for loan consolidation, to provide notice regarding loan consolidation, and for other purposes.

S. 847

At the request of Mr. SMITH, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 847, a bill to amend title XIX of the Social Security Act to permit States the option to provide medicaid coverage for low income individuals infected with HIV.

S. 893

At the request of Mr. SANTORUM, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 893, a bill to amend title VII of the Civil Rights Act of 1964 to establish provisions with respect to religious accommodation in employment, and for other purposes.

S. 894

At the request of Mr. WARNER, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Hawaii (Mr. INOUYE) were added as cosponsors of S. 894, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 230th Anniversary of the United States Marine Corps, and to support construction of the Marine Corps Heritage Center.

S. 902

At the request of Ms. LANDRIEU, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 902, a bill to declare, under the authority of Congress under Article I, section 8, of the Constitution to ''provide and maintain a Navy'', a national policy for the naval force structure required in order to ''provide for the common defense'' of the United States throughout the 21st century.

S. 953

At the request of Ms. LANDRIEU, the name of the Senator from Louisiana (Mr. BREAUX) was added as a cosponsor

of S. 953, a bill to amend chapter 53 of title 5, United States Code, to provide special pay for board certified Federal Employees who are employed in health science positions, and for other purposes.

S. 977

At the request of Mr. FITZGERALD, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 977, a bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage from treatment of a minor child's congenital or developmental deformity or disorder due to trauma, infection, tumor, or disease.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 982

At the request of Mr. SANTORUM, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 982, supra.

S. 985

At the request of Mr. DODD, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 985, a bill to amend the Federal Law Enforcement Pay Reform Act of 1990 to adjust the percentage differentials payable to Federal law enforcement officers in certain high-cost areas, and for other purposes.

S. 1001

At the request of Mr. BIDEN, the names of the Senator from Wisconsin (Mr. FEINGOLD) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 1001, a bill to make the protection of women and children who are affected by a complex humanitarian emergency a priority of the United States Government, and for other purposes.

S. 1046

At the request of Mr. STEVENS, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1115

At the request of Mrs. MURRAY, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1115, a bill to amend the Toxic Substances Control Act to reduce the health risks posed by asbestos-containing products.

S. 1129

At the request of Mrs. FEINSTEIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1137

At the request of Mr. LOTT, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1137, a bill to establish a Mississippi Gulf Coast National Heritage Area in the State of Mississippi, and for other purposes.

S. 1139

At the request of Mr. DEWINE, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1139, a bill to direct the National Highway Traffic Safety Administration to establish and carry out traffic safety law enforcement and compliance campaigns, and for other purposes.

S. 1196

At the request of Mrs. HUTCHISON, the name of the Senator from Nevada (Mr. ENSIGN) was added as a cosponsor of S. 1196, a bill to eliminate the marriage penalty permanently in 2003.

S. 1245

At the request of Ms. COLLINS, the names of the Senator from Nebraska (Mr. HAGEL) and the Senator from Montana (Mr. BURNS) were added as cosponsors of S. 1245, a bill to provide for homeland security grant coordination and simplification, and for other purposes.

S. 1248

At the request of Mr. GREGG, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1293

At the request of Mr. LEAHY, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 1293, a bill to criminalize the sending of predatory and abusive e-mail.

S. 1299

At the request of Ms. SNOWE, the name of the Senator from Alaska (Mr. STEVENS) was added as a cosponsor of S. 1299, a bill to amend the Trade Act of 1974 to provide trade readjustment and development enhancement for America's communities, and for other purposes.

S. 1315

At the request of Mr. CRAIG, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 1315, a bill to amend the Federal Land Policy and Management Act of 1976 to provide owners of non-Federal lands with a reliable method of receiving compensation for damages resulting from the spread of wildfire from nearby forested National Forest System lands or Bureau of Land Management lands, when those forested Federal lands are not maintained in the forest health status known as condition class 1.

S. 1317

At the request of Mr. SMITH, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 1317, a bill to amend the American Servicemember's Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance.

S. 1321

At the request of Mrs. CLINTON, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 1321, a bill to authorize resources to foster a safe learning environment that supports academic achievement for all students by improving the quality of interim alternative educational settings, providing more behavioral supports in schools, and supporting whole school interventions.

S. 1323

At the request of Mr. GRASSLEY, the names of the Senator from Missouri (Mr. BOND) and the Senator from Nebraska (Mr. HAGEL) were added as cosponsors of S. 1323, a bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

S. 1324

At the request of Mr. GRASSLEY, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 1324, a bill to amend the Trade Act of 1974 to establish procedures for identifying countries that deny market access for agricultural products of the United States, and for other purposes .

S. 1325

At the request of Mr. BURNS, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 1325, a bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies.

S. 1331

At the request of Mr. CONRAD, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 1331, a bill to clarify the treatment of tax attributes under section 108 of the Internal Revenue Code of 1986 for taxpayers which file consolidated returns.

S. 1331

At the request of Mr. SANTORUM, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 1331, supra.

S. CON. RES. 25

At the request of Mr. VOINOVICH, the names of the Senator from New York (Mr. SCHUMER) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. Con. Res. 25, a concurrent resolution recognizing and honoring America's Jewish community on

the occasion of its 350th anniversary, supporting the designation of an ''American Jewish History Month'', and for other purposes.

S. CON. RES. 40

At the request of Mrs. CLINTON, the names of the Senator from Florida (Mr. NELSON), the Senator from Illinois (Mr. DURBIN) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as ''National Purple Heart Recognition Day''.

S. RES. 62

At the request of Mr. ENSIGN, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. Res. 62, a resolution calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

S. RES. 153

At the request of Mrs. MURRAY, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. Res. 153, a resolution expressing the sense of the Senate that changes to athletics policies issued under title IX of the Education Amendments of 1972 would contradict the spirit of athletic equality and the intent to prohibit sex discrimination in education programs or activities receiving Federal financial assistance.

S. RES. 169

At the request of Mrs. CLINTON, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. Res. 169, a resolution expressing the sense of the Senate that the United States Postal Service should issue a postage stamp commemorating Anne Frank.

S. RES. 170

At the request of Mr. DODD, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. Res. 170, a resolution designating the years 2004 and 2005 as ''Years of Foreign Language Study''.

S. RES. 184

At the request of Mr. SANTORUM, his name was added as a cosponsor of S. Res. 184, a resolution calling on the Government of the People's Republic of China immediately and unconditionally to release Dr. Yang Jianli, and for other purposes.

AMENDMENT NO. 975

At the request of Mr. SCHUMER, his name was added as a cosponsor of amendment No. 975 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 975

At the request of Mr. CORZINE, his name was added as a cosponsor of amendment No. 975 proposed to S. 1, supra.

AMENDMENT NO. 979

At the request of Mr. AKAKA, the name of the Senator from Virginia (Mr. ALLEN) was added as a cosponsor of amendment No. 979 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 980

At the request of Mr. AKAKA, the name of the Senator from New Mexico (Mr. DOMENICI) was added as a cosponsor of amendment No. 980 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 989

At the request of Ms. COLLINS, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of amendment No. 989 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1004

At the request of Mr. CHAMBLISS, his name was added as a cosponsor of amendment No. 1004 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1017

At the request of Mr. ALLARD, the names of the Senator from Wisconsin (Mr. KOHL) and the Senator from Vermont (Mr. LEAHY) were added as cosponsors of amendment No. 1017 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1031

At the request of Mr. CRAPO, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of amendment No. 1031 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1033

At the request of Ms. MIKULSKI, the names of the Senator from Maryland (Mr. SARBANES), the Senator from Wisconsin (Mr. KOHL) and the Senator from California (Mrs. BOXER) were added as cosponsors of amendment No. 1033 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1040

At the request of Mr. SCHUMER, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of amendment No. 1040 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1060

At the request of Mr. ALEXANDER, his name was added as a cosponsor of amendment No. 1060 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1060

At the request of Mr. MCCAIN, his name was added as a cosponsor of amendment No. 1060 proposed to S. 1, supra.

AMENDMENT NO. 1063

At the request of Ms. COLLINS, the names of the Senator from Washington (Mrs. MURRAY), the Senator from Minnesota (Mr. COLEMAN), the Senator from California (Mrs. BOXER), the Senator from Nebraska (Mr. HAGEL), the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Wisconsin (Mr. KOHL) were added as cosponsors of amendment No. 1063 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1065

At the request of Mr. GRAHAM of Florida, his name was added as a cosponsor of amendment No. 1065 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1073

At the request of Mr. SMITH, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of amendment No. 1073 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1086

At the request of Mrs. MURRAY, her name was added as a cosponsor of

amendment No. 1086 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LEVIN:

S. 1338. A bill to decrease the matching funds requirement and authorize additional appropriations for Keweenaw National Historical Park in the State of Michigan; to the Committee on Energy and Natural Resources.

Mr. LEVIN. Mr. President, I ask unanimous consent that the text of the Keweenaw National Historical Park bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1338

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FUNDING FOR KEWEENAW NATIONAL HISTORICAL PARK.

(a) MATCHING FUNDS.—Section 8(b) of Public Law 102–543 (16 U.S.C. 410yy–7(b)) is amended by striking ''$4'' and inserting ''$1''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 10(a) of Public Law 102–543 (16 U.S.C. 410yy–9(a)) is amended—

(1) by striking ''$25,000,000'' and inserting ''$50,000,000''; and

(2) by striking ''$3,000,000'' and inserting ''$25,000,000''.

Mr. GRAHAM of Florida. Mr. President, I rise today to introduce legislation that will authorize additional judgeships in the Middle and Southern Federal Judicial Districts of Florida.

Additional judgeships are needed in these two districts in order to deal with a large volume of filings, heavy pending caseloads, the considerable number of senior judges, and a rapidly growing population. It is vital that we add two additional permanent and one temporary judgeship in the Middle District and four additional permanent judgeships in the Southern District of Florida.

Florida's Middle District is one of the busiest Federal district courts in the Nation. In 2001 it was ranked fifth in the Nation for the number of criminal defendants charged with fraud and drug related offenses among all district courts. It handles cases filed in three of the four largest cities in the State of Florida, Jacksonville, Orlando and Tampa, which comprise 60 percent of the State's population.

In 1999 four judges were added to the Middle District of Florida. The numbers of weighted filings and pending caseload both decreased in 2000. However, numbers quickly rose again in 2001. A biennial judgeship survey conducted in 2003 showed that in 2001 there were 553 weighted filings in this district versus the national average of 490. In addition, the United States Department of Justice has identified Central Florida as a High Intensity Drug Trafficking Enforcement Area.

The Southern and Middle Districts are parallel in some of the challenges that they face. Despite the additional judgeships that were created in the Southern District in 2001, the amount of weighted filings continues to rise. Since 1994, civil and criminal filings per judgeship have stayed above the national average, with civil filings rising by 67 percent and criminal filings increasing by 58 percent. Many of these increases in criminal filings are linked to the increase in fraud, drugs, firearms and immigration prosecutions.

The administration of justice will continue to be a challenge in Florida's Federal courts unless adequate resources are committed. It is projected that by 2015 Florida may surpass third-ranked New York in population. As the population increases, so do the number of people seeking justice from the Federal courts in our State. I ask that my colleagues join me in supporting this important legislation.

By Mrs. FEINSTEIN:

S. 1342. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Indian Affairs.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce legislation to amend the Graton Rancheria Restoration Act to give the State of California and the local communities of Sonoma, Napa, and Marin counties the opportunity for input and review of the tribe's plan for a major casino in the Bay Area.

I am offering this legislation because the Boards of Supervisors of the local communities impacted by this planned casino have asked me to amend the Graton Rancheria Restoration Act. The Boards of Supervisors of Sonoma, Marin, and Napa counties have each unanimously passed resolutions seeking a change in Federal law to restore the Secretary of Interior's discretion in approving land into trust and allowing the State and local government to have a voice in the process.

Prior to today's introduction I have met with the Presidents of the Sonoma and Marin Boards of Supervisors, the Graton tribe, and Senators CAMPBELL and INOUYE the Chairman and Ranking Member of the Indian Affairs Committee.

This week I had a very spirited and frank conversation with Graton Tribal Chairman Greg Sarris and representatives from the casino investors. During the meeting Chairman Sarris committed to work with the local Boards of Supervisors and he committed to look at alternative sites for the casino. Chairman Sarris also said the Tribe and the casino investors would conduct an environmental review based on the criteria laid out in the National Environmental Policy Act, NEPA, before a site is selected. These are positive signs and I have told both the Boards of Supervisors and the Tribe that I would like to see them continue to work together.

This legislation guarantees that the local and State officials have a voice in the process. Without this change to the Graton Rancheria Restoration Act they do not have that voice.

In 2000, Congress passed the Graton Rancheria Restoration Act to restore Federal recognition to the 355 members of the Federated Indians of the Graton Rancheria.

The Graton Tribe's original Rancheria was in the northern Sonoma County town of Graton on land purchased by the Bureau of Indian Affairs, BIA, in 1920 for the ''village home'' of otherwise homeless Miwok and Pomo Indians. The Rancheria was terminated in 1958 when the BIA approved a plan to distribute the assets to resident Indians and remove the Rancheria from Federal trust.

The original version of the Graton restoration bill, H.R. 946, sponsored by Congresswoman LYNN WOOLSEY in the 106th Congress, passed the House of Representatives with a gaming restriction, to which the Tribe agreed.

In testimony before the House Resources Committee in May 2000, and in other public comments, Graton Chairman Greg Sarris stated that the Tribe had no intention of conducting gaming.

In fact, before the House Resources Committee, Chairman Sarris stated, ''Many may think our motives for restoration have been influenced by the opportunity gaming affords some other recognized tribes. Because our local political constituency, both democratic and republican has opposed any sort of development for environmental reasons, we agreed with these local political forces to not develop a gaming complex. So, as proof, we voted as a tribe to include a non-gaming clause in our bill, stipulating that we will not be a gaming tribe.''

Furthermore, in an article in the Marin Independent Journal on September 21, 2000, Chairman Sarris said, ''All we want is to be formally recognized as Indians and have the same rights that other Indians do for education and health care. We are not interested in gambling.'' I ask unanimous consent to print a copy of this article in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Marin Independent Journal, Sept. 21, 2000]

GAMBLING DISPUTE THREATENS MIWOK BILL

(By Gannet News Service)

WASHINGTON.—Legislation to formally reestablish the identity and standing of Marin's band of Coast Miwok Indians appears all but dead in the face of a House-Senate dispute over how tight guarantees must be that the tribe will never allow casino gambling.

''This is insane, this is frustrating, and I just can't see why we can't find a way out of this,'' said Greg Sarris, the tribe's chief who is an English professor at UCLA.

Rep. Lynn Woolsey, the Petaluma Democrat who authored the original bill, said she shares the frustration but sees little hope other than the fact that ''down the road there will be other Congresses.''

The problem is that the bill to restore the all-but-vanquished tribe, approved by the full House in June, included specific language that waived in perpetuity any right to establish gaming on the tribe's remaining one-acre ancestral plot in the Sonoma County town of Graton.

Woolsey sought that waiver in agreement with the tiny tribe. In hearings last spring and summer, she and Sarris said the tribe was happy to agree to the waiver. They were not interested in gaming, and their acreage was too small even if they were interested. Additionally, the fine print in a state-passed referendum in California to divide gaming resources among tribes prevents them from operating any kind of casino.

Adding a federal gaming ban on top of an existing state ban was an easy and harmless layer of extra insurance to reassure the community that the tribe would not be bringing high-stakes bingo to Marin.

''All we want is to be formally recognized as Indians and have the same rights that other Indians do for education and health care,'' said Sarris, one of some 300 descendants of the tribe that the government declared extinct in the 1950s. ''We are not interested in gambling.''

But when the bill reached the Senate as an identical version of the bill sponsored by Sen. Barbara Boxer, D-Calif., numerous Indian advocates and the government's Bureau of Indian Affairs objected. The surrender of sovereignty by the Miwoks, however well-intentioned, would set a precedent that could be used against other tribes in other states—in effect a means to pressure tribes on the sensitive issue of gambling.

''It's not that we don't have sympathy with what the Miwoks want to do, or in this case don't want to do. It's a question of eroding the hard-won sovereignty that is the legal basis for the gambling that has been an important resource of many tribes,'' said John Sanchez, an expert on Indian sovereignty at Pennsylvania State University and a member of the Apache tribe.

Boxer's spokesman, David Sandretti, said his bill was still hopeful, but the key lawmaker on the issue is Sen. Daniel Inouye of Hawaii, vice chairman of the Indian Affairs Committee and long a powerful voice on behalf of American Indians and native Hawaiians. Without his support, the bill wouldn't survive in the Senate, Sandretti said.

Inouye made it clear this week that the bill is dead unless Woolsey agreed to drop the gambling ban in her legislation.

''If you set that precedent, that creates a lot of problems,'' Inouye said. ''I would prefer to see a measure without the waiver, and if I do I'd be likely to support it.''

Inouye added that it's a meaningless, symbolic waiver to begin with, because the tribe is already prevented from opening a casino by state law. ''I just don't think this is something that the federal government should be involved in,'' he said.

Woolsey said she has no intention of agreeing to anything that doesn't include the anti-gaming clause as written.

''I got it out of the House, and now it's in the Senate, and I guess that's just where it is,'' Woolsey said. ''I've heard some proposals for compromise, but I haven't seen anything that would offer the level of protection against gaming that the community and the 6th Congressional District would be prepared to accept.''

Gene Buvelot of Novato, vice chairman of the Federated Indians of Graton Rancheria, said his group is disappointed in Woolsey, because members believe she should allow the bill to go forward without the clause.

''We're disappointed, deeply disappointed with Woolsey because she seems to be the one who's dropped the ball on this, not Barbara Boxer,'' he said. ''It's a shame that it's getting this far and that Woolsey is letting it bog down like this.''

Coast Miwok tribal elder Joanne Campbell, a former Marin resident now living in Daly City, said she often visited her great aunt at the Miwok's Graton Rancheria in Sonoma County.

''I'm really steamed, I'm just so upset that this bill maybe will not pass,'' Campbell said. ''I think it's a just bill and it's about time we got some recognition because we have all these other issues to deal with, Health issues, education issues, and we need this recognition to move forward.''

The bill would make the tribe eligible for a wide range of U.S. and California health, education and housing grants and assistance from various federal agencies, give the tribe the right to establish a reservation and exempt the tribe from some local, state, or federal taxes and local zoning ordinances on reservation land.

If the bill is not passed by Oct. 5, when the Senate recesses, a new restoration bill would have to wait until the next Congress.

Camobell described Woolsey's refusal to drop the redundant anti-gaming clause from the Senate version as ''unrelenting'' and ''unreasonable.''

Mrs. FEINSTEIN. Senator BOXER sponsored legislation identical to Congresswoman WOOLSEY'S in the Senate, but the gaming restriction was stricken when the bill was ultimately passed as part of the Omnibus Indian Advancement Act of 2000.

The day the legislation passed on December 11, 2000, Senator BOXER stated on the Senate Floor that dropping the gaming restriction was necessary because of opposition to the no-gaming clause by the Senate Committee on Indian Affairs and the Clinton Administration and because, according to Senator BOXER, ''Senator INOUYE asserts that the no-gaming clause is unnecessary because the Graton Rancheria have no intention of conducting gaming.''

So what has changed one might ask?

Well, even though the Gratons voluntarily and repeatedly took a no-gaming pledge while their restoration bill was under consideration by Congress, on April 23, 2003, the Tribe and its partner, Stations Casinos of Las Vegas, announced plans to purchase approximately 2,000 acres of land in Southern Sonoma County near Sears Point for the development of a casino.

This site is located on environmentally sensative open space and San Francisco—North Bay tidelands which have been the subject of a decades-long conservation effort by environmentalists and local residents.

This site is roughly 30 miles from San Francisco—along the gateway to Sonoma that leads thousands of travelers into the beautiful wine country each day.

The Tribe's casino proposal has outraged local elected officials and residents who had sympathized with the Tribe's plight and supported their restoration on the condition that they not seek to develop a casino. The Sonoma and Marin County Boards of Supervisors have each passed unanimous resolutions objecting to the Graton casino proposal. In fact, even the Board of Supervisors of neighboring Napa has also passed a resolution against the casino proposal. I ask unanimous consent to print these resolutions and letters from the counties in the RECORD.

There being no objection, the materials were ordered to be printed in the RECORD, as follows:

MARIN COUNTY, SAN RAFAEL, CA
AND SONOMA COUNTY, SANTA ROSE, CA,

May 29, 2003.

Senator DIANNE FEINSTEIN,
U.S. Senate,
San Francisco, CA.

DEAR SENATOR FEINSTEIN: We write this joint letter to request your assistance with an urgent matter facing Marin and Sonoma counties. As you are aware, the Graton Rancheria Tribe has announced plans to acquire lands adjacent to the San Pablo Bay National Wildlife Refuge and to construct a major casino in partnership with Stations Casinos of Las Vegas. The proposal came as a shock to us since, at the time it sought restoration in 2000, the Graton tribe represented to Congress that it would not engage in gaming. It now appears that the Secretary of the Interior believes she must take into trust any land within our counties acquired by the tribe, and that gaming will be permitted on these lands without consultation with local governments or discretionary review by the Secretary.

We ask that you sponsor legislation to require that tribal trust land acquisitions be subject to consultation with local governments and an appropriate administrative review. We ask that restored tribal land acquired for gaming be subject to the two part test that it is not detrimental to the community and is supported by the Governor. Finally, we ask that the Secretary be given discretion with respect to accepting land into trust for the benefit of the Graton tribe. County Counsel from our two counties have prepared a letter to you providing background and supporting details regarding our proposals.

We know that you share our concern about the proliferation of casinos in California, especially those which are close to metropolitan areas or have impacts on sensitive lands.

We look forward to working with you to bring about changes in the law which can advance the economic interests of tribes without harm to the local community.

Very truly yours,

ANNETTE ROSE,
President, Marin County Board of Supervisors.
PAUL KELLEY,
Chairman, Sonoma County Board of Supervisors.

RESOLUTION NO. 03–0512

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay;

Whereas, the agricultural lands along Lakeville Highway afford an invaluable agricultural and scenic resource, not only to the people of Sonoma County but to the populace of the entire Bay Area;

Whereas, such lands provide one of the Bay Area's most cherished community separators, and represent an important scenic gateway to Sonoma County;

Whereas, these bay, agriculture and wet lands have been the focus of preservation and conservation efforts by environmentalists and local communities for many years;

Whereas, based upon press reports, approximately 2,000 acres of such lands are presently in imminent danger of being withdrawn from County land use control and placed into trust for the purposes of casino development—including the potential of an extensive gaming complex, including a hotel, parking and other support services as well as possible residential development, by Station Casinos, a Las Vegas-based developer and the Federated Indians of the Graton Rancheria (''Tribe'');

Whereas, the Tribe was restored in 2000 based, in part, on its promise not to engage in Indian casino gaming;

Whereas, the federal legislation restoring the Tribe contains language that could be used to circumvent the normally required environmental review and administrative regulatory process for taking land into trust by the United States government on behalf of the Tribe;

Whereas, the Tribe's gaming plans were announced in the media without any government to government consultation with affected local communities;

Whereas, the Board and Tribe have initiated communication regarding the proposed casino but details regarding the project and siting have not yet been made available;

Whereas, the proposed project could overwhelm the local infrastructure in the area in which the casino project is proposed;

Whereas, the environmental impacts of the prosed project have the potential of being are reaching and of such a magnitude that they would negatively affect a significant portion of the North Bay, including grossly aggravating existing traffic problems along State Highways 37 and 101 (as well as County roads in the project vicinity), pose severe water quality risks, and have profound negative visual impacts in the scenic area;

Whereas, when California voters approved Proposition 1A (Indian Gaming) in March of 2000 as a means of supporting the laudable goal of Indian economic development and self-sufficiency, they were not aware that such approval would allow Nevada developers to seize prized off-reservation environmental resources of intense development without regarding to locally approved general plans or any meaningful environmental review or protection;

Whereas, under the provisions of Proposition 1A and the Tribal-State Compact, local communities have been granted no effective input into the development of proposed tribal casinos that threaten their rights and the State appears to have no effective redress for significant environmental impacts these gambling casinos impose on local communities: Now, therefore, be it

Resolved, That the Sonoma County Board of supervisors, based on the information currently available, strongly opposes the creation of a gambling casino on the site proposed by the Tribe; and be it further

Resolved, That County staff is directed to enter into good faith discussions with tribal representatives for the purposes of facilitating government to government communications, exploring casino development and reviewing alternative sites, as well as minimizing and mitigating environmental impacts of any casino project; be it further

Resolved, That County staff is authorized to take all reasonably required action, including submitting comments to agencies involved in considering the trust application and casino proposal, requesting assistance from State and Federal elected representative, proposing legislation, participating in administrative proceedings, and initiating litigation to insure that any proposed gaming project in Sonoma County complies with the county General Plan and meets all federal and state environmental, public health, and public safety requirements that otherwise would apply to a non-Indian development project, and to require that any land proposed to be taken into trust goes through a thorough regulatory and environmental review process.

RESOLUTION NO. 2003–70

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly in to the Bay; and

Whereas, the Federated Indians of Graton Rancheria have announced their intention to acquire 2000 acres of land along Highway 37 and develop a casino, hotel, housing and related development on this precious natural resource; and

Whereas, the impact on traffic of a development of this magnitude will be felt throughout the North Bay, with this single development jeopardizing all traffic capacity with local jurisdictions have husbanded for purposes consistent with their respective General Plans; and

Whereas, when Congress passed the Graton Rancheria Restoration Act, the Federated Indians of Graton had pledged not to engage in gaming on any lands placed in trust by the federal government; and

Whereas, the Federated Indians of the Graton Rancheria take the position that under the provisions of the Graton Rancheria Restoration Act, and the tribal state compact, local residents have no effective input into the development of the proposed tribal casino, yet these residents nevertheless bear the resultant environmental, societal, traffic, infrastructure, public safety, and other burdens which these gambling casinos impose on their communities: Now, therefore, be it

Resolved, that the Board of Supervisors of the County of Marin calls on its elected members of the United States Senate, Dianne Feinstein and Barbara Boxer, and its elected member of the House of Representative, Lynn Woolsey, to assist the residents of Marin and the entire North Bay to preserve their environment by introducing legislation that would amend the Graton Rancheria Restoration Act and/or the Indian Gaming Regulatory Act to stop the unregulated creation of tribal lands and to subject any development of tribal lands in the newly acquired tribal lands by the Indian Gaming Regulatory Act.

RESOLUTION NO. 03–94

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay; and

Whereas, the agricultural lands along Lakeville Highway afford an invaluable agricultural and scenic resource, not only to the people of Sonoma County but also to the populace of the entire Bay Area; and

Whereas, such lands provide one of the Bay Area's most cherished community separators, enjoyed and remembered by all who traverse Highway 37; and

Whereas, these agricultural lands, bay and wetlands have been the focus of preservation and conservation efforts by environmentalists and local communities for many years; and

Whereas, such land are presently in imminent danger of intense development—including an enormous casino, a high-rise hotel, an amphitheater, a residential development, and acres of parking—by Station Casinos, a Las Vegas-based developer, and

Whereas, the impact on traffic of a development of this magnitude will be felt throughout the North Bay, with this single development jeopardizing all traffic capacity, which local jurisdictions have husbanded for purposes consistent with their respective General Plans; and

Whereas, when California voters approved Proposition 1A (Indian Gaming) in March 2000 as a means of supporting the laudable goal of Indian economic development and self-sufficiency, they had no way of knowing that such approval would allow Nevada developers to seize our most prized environmental resources for intense development in violation of all local zoning controls and health and safety ordinances; and

Whereas, under the provisions of Proposition 1A and the tribal state compact, local residents have been granted no effective input into the development of proposed tribal casinos that threaten their civil and property rights, yet these residents must nevertheless bear the resultant environmental, societal, traffic, infrastructure, public safety, and other burdens that these gambling casinos impose on their communities: Now, therefore, be it

Resolved, That the Board of Supervisors of the County of Napa strongly oppose the creation of a gambling casino along highway 37 or Lakeville Highway; and be it further

Resolved, That the Board of Supervisors of the County of Napa calls on Governor Davis, the California State Legislature, the U.S. Congress, and the U.S. Department of the Interior to take any and all steps within their powers and prerogatives to block the creation of new tribal land bases that are intended for gambling casinos and other development inconsistent with local zoning and controls and to require that all commercial development on new and existing tribal lands comply with federal, state, and local laws and regulations intended to safeguard the environment and to protect public health and safety.

Mrs. FEINSTEIN. Let me just read one part of the Resolution from Marin County which will give you an idea of the opposition to the Graton tribe's proposed casino:

RESOLVED, that the Board of Supervisors of the County of Marin calls on its elected members of the United States Senate, DIANNE FEINSTEIN and BARBARA BOXER, and its elected member of the House of Representatives, LYNN WOOLSEY, to assist the residents of Marin and the entire North Bay to preserve their environment by introducing legislation that would amend the Graton Rancheria Restoration Act and/or the Indian Gaming Regulatory Act to stop the unregulated creation of tribal lands and to subject development of tribal lands in the Marin and Sonoma Counties at a minimum to the regulatory and approval processes applicable to newly acquired tribal lands by the Indian Gaming Regulatory Act.

While the counties acknowledge that the Graton have a right to be recognized, they object to the site selected by the tribe and they especially object to language in the Restoration Act

that precludes the local community, the Governor, or the Secretary of the Interior from providing input on the suitability of this location for land taken into trust for gaming purposes.

There is a problematic section of the Restoration Act that states, ''Upon application by the Tribe, the Secretary shall accept into trust for the benefit of the Tribe any real property located in Marin or Sonoma County . . .'' According to the Department of the Interior, this language removes any discretion by the Secretary as well as any tribal obligations for consultation with the surrounding community or environmental review, as required by the normal process under the Indian Gaming Regulatory Act for newly acquired land taken into trust for gaming purposes.

According to the Department of the Interior, the tribe must only conduct a hazardous materials review and show title to the land for land to be taken into trust. This could be completed in 9 months—and it is an inadequate review in my opinion.

Since the local communities are seeking a remedy which would restore the Secretary's discretion in approving its land trust application and allow local government to provide input in the process, I am introducing this legislation today that will change the ''shall take land into trust'' to ''may take land into trust.'' This legislation will also require the two-part test that is standard under the Indian Gaming Regulatory Act of 1988 to apply so that the State and local communities have input in the process.

There is precedent for this change. In 1994, legislation was passed restoring the United Auburn Tribe with the same directive to the Secretary of the Interior, requiring that land ''shall'' be taken into trust for the Tribe. One of the restoration act's sponsors, Congressman JOHN DOOLITTLE sponsored an amendment to change ''shall'' to ''may'' after it had been passed, thereby affording the Secretary of Interior discretion in accepting particular parcels of land into trust and local government officials an opportunity to weigh in on the Tribe's proposed site.

The result of that change was that the Auburn Tribe and Placer County officials successfully cooperated in not only identifying a mutually agreeable site, but they signed a Memorandum of Understanding to mitigate potential impacts from the proposed Thunder Valley Casino. And earlier this month, the tribe opened its casino.

Today California is home to 109 federally recognized tribes. 61 tribes have gaming compacts with the State and there are 54 tribal casinos. With more than 50 tribes seeking Federal recognition and approximately 23 recognized tribes seeking gaming compacts from the Governor, revenues from California's tribal gaming industry are expected to surpass Nevada's by the end of the decade.

The dramatic growth in tribal gaming in California has the potential to yield much needed benefits for tribal members in terms of healthcare, education and general welfare, as Congress and California voters intended. However, the question is not whether gaming should be permitted, but rather how and where. Those questions were asked and answered in the Indian Gaming Regulatory Act of 1988, IGRA. But without the modest change made by this legislation, the Graton tribe will be allowed to develop an off-reservation casino outside the requirements established in IGRA, the first time such an exception has ever been made for a California tribe. Allowing this to happen would set a dangerous precedent not only for California, but every State where tribal gaming is permitted.

The changes we are seeking today are extremely modest. We are not reversing any restoration of the tribe. We are not infringing on Native American sovereignty. We are not even blocking the casino proposal. We are only seeking to give the State and the local communities a voice in the process. They were promised the tribe would not open a casino. That promise was broken, so the least we can do is ensure a normal review will take place.

I hope my colleagues will support this legislation and I look forward to working with the Chairman and Ranking Member of the Indian Affairs Committee to pass this legislation quickly.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1342

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. AMENDMENT TO GIVE SECRETARY DISCRETION CONCERNING LANDS TAKEN INTO TRUST.

(a) REVIEW.—Section 1404 of the Graton Rancheria Restoration Act (25 U.S.C. 1300n–2) is amended by adding at the end the following new subsection:

''(f) REVIEW.—No land taken into trust for the benefit of the Tribe shall be construed to satisfy the terms for an exception under section 20(b)(1)(B) of the Indian Gaming Regulatory Act (25 U.S.C. 2719(b)(1)(B)) to the prohibition on gaming on lands acquired by the Secretary in trust for the benefit of an Indian tribe after October 17, 1988, under section 20(a) of such Act (25 U.S.C. 2719(a)).''.

(b) LAND INTO TRUST.—Section 1405(a) of the Graton Rancheria Restoration Act (25 U.S.C. 1300n–3(a)) is amended by striking ''shall'' and inserting ''may''.

By Mr. CORZINE (for himself, Mr. SCHUMER, Mr. AKAKA, and Mrs. BOXER):

S. 1344. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. CORZINE. Mr. President, today, along with my distinguished colleagues Senators SCHUMER, AKAKA, and BOXER, I am introducing ''The Money Wire Improvement and Remittance Enhancement Act'' (The ''Money WIRE Act''), legislation that will protect consumers who send cash remittances through international money wire transmitters by providing them with increased disclosure of the exchange rate and service fees, as well as hidden costs, for those transactions. The legislation also expands access to mainstream money wiring, check cashing, and other important services for millions of the unbanked in America, particularly immigrants, through our Nation's credit unions.

Every year, thirty million Americans send their friends and relatives $40 billion in cash remittances through wire transfers. The majority of these transfers are remittances sent to their native countries by immigrants to the United States. For these individuals, many of whom are in low-to-minimum wage jobs, sending this money only increases their own personal financial burdens—but they do so to aid their families and their loved ones.

Unfortunately, these immigrants increasingly find themselves being preyed upon by the practices of some money wire transfer providers who not only charge consumers with an upfront charge for the money wire transfer service, but also hit them on the back end with hidden costs. Many of these charges are extracted when the dollars sent by the consumer are converted to the foreign currency value that is supposed to be paid out to the friend of the family member.

This exploitation is especially pervasive in Latin American and Caribbean countries, where much of these types of transactions occur. According to the Multilateral Investment Fund and the Inter-American Development Bank, Latin American and Caribbean immigrants sent a record $32 billion to their home countries in 2002—a dramatic increase compared with $23 billion in 2001. Many of these dollars were used to pay for basic needs, such as food, medicine, and schooling, and to alleviate the suffering of loved ones during a difficult economic year.

To bring this amount into even greater perspective, the remittances that flowed into Latin America and the Caribbean last year equaled roughly the amount of direct foreign investment that flowed into the region, and exceeded the amount of development aid to Latin America from all sources. For this decade alone, Latin America and the Caribbean could receive more than $300 billion. And experts believe that number is likely to grow significantly in coming years.

These large cash flows have proven to be a powerful incentive for greed in the case of some wire transfer companies. Customers wiring money to Latin America and elsewhere in the world lose billions of dollars annually to undisclosed ''currency conversion fees,'' and other service costs.

In fact, many large companies aggressively target immigrant communities, often advertising ''low fee'' or ''no fee'' rates for international transfers. But these misleading ads do not always clearly disclose the fees charged when the currency is exchanged.

While large wire service companies typically obtain foreign currencies at bulk rates, they charge a significant currency conversion fee to their U.S. customers. For example, customers wiring money to Mexico are charged an exchange rate that routinely varies from the benchmark by as much as 15 percent. These hidden fees create staggering profits, allowing companies to reap billions of dollars on top of the stated fees they charge for the wire transfer services.

Last year alone, immigrants who sent money to Latin America and the Caribbean paid approximately $4 billion in transaction costs to the money wire transfer companies that dominate this business. In other words, for every $100 that an immigrant sent home, to help their family and loved ones, $12 was siphoned off by these businesses in order to ''service'' that transaction.

That adds up to a $20-$30 average cost, occasionally it can be considerably more, for poor, hard-working folks for whom the typical remittance—around $250 to $300 a month—represents a significant percentage of their monthly income.

Multiplied by millions, these excessive charges constitute a significant major economic force. These millions could have otherwise been used to feed children, house a family, or invest in a small business—all of which markedly improve overall quality of life.

The ''Money WIRE Act'' would require money wire transmitting businesses to disclose to senders, and receivers, of international money wire transfers the exchange rate used in association with the transaction; any surcharges, commissions or fees charged to the customer for the service; and the exact amount of the foreign currency to be received by the recipient in the foreign country.

It also requires that that rate and fee information be prominently displayed at the wire transmitting service location and on all receipts associated with the money wire transaction—and it ensures that those disclosures occur in the same language as that principally used by the business to advertise its money transmitting services, if that language is other than English.

The bill also requires Federal banking regulators and the Department of Treasury to conduct a study, and submit a report to Congress, of the fees and fees disclosure at traditional financial institutions compared to those that occur at money transmitting businesses for money wire transactions.

Finally, the Act includes a provision that expands the ''field of membership'' definition for credit unions to give nonmembers, particularly unbanked and immigrant communities, access to credit unions for international money transfer, money order, and check cashing services, where the costs for these services are significantly less.

This legislation does more than merely provide better information to consumers—it actually helps them and their families financially. Consumers will see increased competition among wire transfer service providers because they are better-informed and more knowledgeable. That competition will result in lower fees for the wire transfer services that will free up a greater portion of these cash remittances to go to the friends and families that they were originally intended for.

In short, this is sound public policy that empowers those who do their part to help America's economy move forward.

I hope that my colleagues will support this legislation and I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1344

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Money Wire Improvement and Remittance Enhancement Act of 2003'' (or the ''Money WIRE Act of 2003'').

SEC. 2. DISCLOSURE OF EXCHANGE RATES IN CONNECTION WITH INTERNATIONAL MONEY TRANSFERS.

(a) IN GENERAL.—The Electronic Fund Transfer Act (15 U.S.C. 1693 et seq.) is amended—

(1) by redesignating sections 918, 919, 920, and 921 as sections 919, 920, 921, and 922, respectively; and

(2) by inserting after section 917 the following new section:

''SEC. 918. DISCLOSURE OF EXCHANGE RATES IN CONNECTION WITH INTERNATIONAL MONEY TRANSFERS.

''(a) DEFINITIONS.—

''(1) INTERNATIONAL MONEY TRANSFER.—The term 'international money transfer' means any money transmitting service involving an international transaction which is provided by a financial institution or a money transmitting business.

''(2) MONEY TRANSMITTING SERVICE.—The term 'money transmitting service' has the meaning given to such term in section 5330(d)(2) of title 31, United States Code.

''(3) MONEY TRANSMITTING BUSINESS.—The term 'money transmitting business' means any business which—

''(A) provides check cashing, currency exchange, or money transmitting or remittance services, or issues or redeems money orders, travelers' checks, and other similar instruments; and

''(B) is not a depository institution (as defined in section 5313(g) of title 31, United States Code).

''(b) EXCHANGE RATE AND FEES DISCLOSURES REQUIRED.—

''(1) IN GENERAL.—Any financial institution or money transmitting business which initiates an international money transfer on behalf of a consumer (whether or not the consumer maintains an account at such institution or business) shall provide the following disclosures in the manner required under this section:

''(A) The exchange rate used by the financial institution or money transmitting business in connection with such transaction.

''(B) The exchange rate prevailing at a major financial center of the foreign country whose currency is involved in the transaction, as of the close of business on the business day immediately preceding the date of the transaction (or the official exchange rate, if any, of the government or central bank of such foreign country).

''(C) All commissions and fees charged by the financial institution or money transmitting business in connection with such transaction.

''(D) The exact amount of foreign currency to be received by the recipient in the foreign country, which shall be disclosed to the consumer before the transaction is consummated and printed on the receipt referred to in paragraph (3).

''(2) PROMINENT DISCLOSURE INSIDE AND OUTSIDE THE PLACE OF BUSINESS WHERE AN INTERNATIONAL MONEY TRANSFER IS INITIATED.—The information required to be disclosed under subparagraphs (A), (B), and (C) of paragraph (1) shall be prominently displayed on the premises of the financial institution or money transmitting business both at the interior location to which the public is admitted for purposes of initiating an international money transfer and on the exterior of any such premises.

''(3) PROMINENT DISCLOSURE IN ALL RECEIPTS AND FORMS USED IN THE PLACE OF BUSINESS WHERE AN INTERNATIONAL MONEY TRANSFER IS INITIATED.—The information required to be disclosed under paragraph (1) shall be prominently displayed on all forms and receipts used by the financial institution or money transmitting business when initiating an international money transfer in such premises.

''(c) ADVERTISEMENTS IN PRINT, BROADCAST, AND ELECTRONIC MEDIA AND OUTDOOR ADVERTISING.—The information required to be disclosed under subparagraphs (A) and (C) of subsection (b)(1) shall be included—

''(1) in any advertisement, announcements, or solicitation which is mailed by the financial institution or money transmitting business and pertains to international money transfer; or

''(2) in any print, broadcast, or electronic medium or outdoor advertising display not on the premises of the financial institution or money transmitting business and pertaining to international money transfer.

''(d) DISCLOSURES IN LANGUAGES OTHER THAN ENGLISH.—The disclosures required under this section shall be in English and in the same language as that principally used by the financial institution or money transmitting business, or any of its agents, to advertise, solicit, or negotiate, either orally or in writing, at that office if other than English.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect at the end of the 3-month period beginning on the date of the enactment of this Act.

SEC. 3. STUDY ON FEE DISCLOSURES FOR MONEY WIRE TRANSMISSIONS.

(a) STUDY.—The Federal banking agencies (as defined in section 3 of the Federal Deposit Insurance Act) and the Secretary of the Treasury shall jointly conduct a study on fees charged and fee disclosures for money wire transmissions.

(b) COMPARISON OF PRICES.—The study required by subsection (a) shall compare the disclosures provided by federally insured depository institutions for money wire transmissions with disclosures provided by money transmitting businesses (as defined in section 5330(d)(1) of title 31, United States Code) for such transmissions.

(c) REPORT REQUIRED.—The Federal banking agencies and the Secretary of the Treasury shall jointly submit a report on the study required under subsection (a) to the Congress before the end of the 1-year period beginning on the date of enactment of this Act.

SEC. 4. FEDERAL CREDIT UNION ACT AMENDMENT.

Paragraph (12) of section 107 of the Federal Credit Union Act (12 U.S.C. 1757(12)) is amended to read as follows:

''(12) in accordance with regulations prescribed by the Board—

''(A) to sell, to persons in the field of membership, negotiable checks (including travelers checks), money orders, and other similar money transfer instruments; and

''(B) to cash checks and money orders for persons in the field of membership for a fee;''.

Mr. AKAKA. Mr. President, I rise as a cosponsor of the Money Wire Improvement and Remittance Enhancement Act introduced by my colleague, Senator CORZINE. I thank Senator CORZINE for his leadership on this issue.

Immigrants often send a portion of their hard-earned wages to their relatives abroad. Remittances are often used to improve the standard of living of recipients by increasing access to health care, education, and essentials of daily life. In addition, remittances contribute significantly to the economic development of nations. For example, Philippines workers across the globe sent an estimated $6.4 billion back to the Philippines in 2001.

Despite the tremendous importance of remittances, people who send them are often unaware of the fees and exchange rates assessed in these transactions which reduce the amount of money received by their family members. Fees for sending remittances often can be ten to twenty percent of the value of the transaction. Also, the exchange rate used in the transaction can be significantly lower than the market rate.

Consumers and their families cannot afford to remain uninformed about their financial service options and the fees placed on their transactions. This legislation would ensure that each customer is fully informed of all of the fees and the exchange rates used in sending money.

I am hopeful that the enactment of this legislation will result in more people utilizing banks and credit unions for remittances because these institutions do not charge the exorbitant fees often associated with remittances processed by certain other entities. In addition, if unbanked immigrants take advantage of the remittance services offered by banks and credit unions, they will be more likely to open up an account. This would allow immigrants to take advantage of the opportunities for saving and borrowing found at mainstream financial institutions and offer them alternatives to fringe banking products, such as check cashing services.

The Money Wire Improvement and Remittance Enhancement Act has special significance to my home State of Hawaii. Hawaii is home to significant numbers of recent immigrants from many nations, including the Philippines, who send remittances to their relatives abroad. We must do what we can to ensure that their hard-earned dollars are not eroded by unnecessary fees or a lack of transparency regarding exchange rates.

I encourage my colleagues to support this much-needed legislation.

By Mrs. MURRAY (for herself, Mrs. BOXER, Ms. CANTWELL, Mrs. CLINTON, Mr. CORZINE, Mr. EDWARDS, Mrs. FEINSTEIN, Mr. KENNEDY, Mr. LAUTENBERG, Mr. SCHUMER, and Mr. HOLLINGS):

S. 1345. A bill to extend the authorization for the ferry boat discretionary program, and for other purposes; to the Committee on Environment and Public Works.

Mrs. MURRAY. Mr. President, I rise today to introduce legislation that will greatly enhance Federal participation in financing and improving our Nation's ferry transportation system.

Today I am introducing the Ferry Transportation Enhancement Act. I am proud to have Senators BOXER, CANTWELL, CORZINE, CLINTON, EDWARDS, FEINSTEIN, HOLLINGS, KENNEDY, LAUTENBERG, and SCHUMER as original cosponsors. This bill will provide significantly more resources to state governments, public ferry systems, and public entities responsible for developing facilities for ferries.

Specifically, the bill would: provide $150 million a year for the Federal Highway Administration's Ferry Boat Discretionary Program for fiscal years 2004 through 2009. This is approximately four times the $38 million a year that is currently being provided under this program; add ''ferry maintenance facilities'' to the list of allowable use of funds under this program; add ''ferries'' to the Clean Fuels Program; establish a Ferry Joint Program Office to coordinate Federal programs affecting ferry boat and ferry facility construction, maintenance, and operations and to promote ferry service as a component of the Nation's transportation system; establish an information database on ferry systems, routes, vessels, passengers and vehicles carried; and establish an institute for ferries to conduct R&D, conduct training programs, encourage collaborative efforts to promote ferry service, and preserve historical information. This will parallel institutes that now exist for highways, transit, and rail.

Currently, the Federal investment in ferries is only one-tenth of one percent of the total Surface Transportation Program. There is virtually no coordination at the Federal level to encourage and promote ferries as there are for other modes of transportation.

We need better coordinated ferry services because it's the sole means of surface transportation in many areas of the country, including Hawaii, Alaska and my home State of Washington.

Ferries are also the preferred, and the only feasible, method of commuting from home to work in places like Washington State, New York/New Jersey, North Carolina, Hawaii and Alaska.

Finally, in many States—like my home State of Washington—they are an important part of the tourism industry and represent a part of our cultural identity.

The symbol of ferries moving people and vehicles on the waterways of the Puget Sound is as much a part of our cultural identity as computers, coffee, commercial aircraft and the Washington Apple.

Ferry use is growing.

In Washington State our ferry system—the Nation's largest—currently transports 26 million passengers each year and carries 11 million vehicles.

Other systems that serve New York/New Jersey, North Carolina, San Francisco, and Alaska also have significant numbers of passengers using the ferries.

The Nation's six largest ferry systems carried 73 million people and 13 million vehicles last year.

The growth projection for ferry use is very high. For these larger systems, it is projected that by 2009 there will be a 14-percent increase in passengers and a 17-percent increase in vehicles being carried by ferries compared to 2002.

In San Francisco, that projection is a 46-percent increase.

It is clear that many people are using ferries and more will be using them in the future.

This is all with very little help from the Federal Government.

Our investment in ferries pails in comparison to the Federal investments in highways and other forms of mass transit.

Our bill would provide the needed funding for these growing systems for new ferry boat construction, for ferry facilities and terminals, and for maintenance facilities.

The bill also would make ferries eligible under the Clean Fuels Program.

Like busses, ferries are a form of mass transit that is environmentally cleaner than mass use of cars and trucks. Making them eligible for the Clean Fuels Program will encourage boat makers to design cleaner and more efficient vessels in the future. This will make ferry travel an even more environmentally friendly means of transportation than it already is today.

Finally, setting up a Ferry Joint Program Office, keeping track of ferry statistics, and establishing a National Ferry Institute will increase the profile of ferries as part of our Nation's infrastructure and provide a method to analyze and research ways to improve their use.

In the end, I hope this proposal can be included in the TEA–21 Reauthorization.

Ferries are an important part of our Nation's transportation infrastructure.

This bill recognizes their importance by providing the resources and support they need to grow and serve passengers.

I urge the Senate support this bill, and I look forward to working with my colleagues to see it passed.

By Ms. CANTWELL (for herself and Ms. COLLINS):

S. 1346. A bill to amend the Workforce Investment Act of 1998 to provide for strategic sectoral skills gap assessments, strategic skills gap action plans, and strategic training capacity enhancement seed grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1347. A bill to amend the Workforce Investment Act of 1998 to provide for training service and delivery innovation projects; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1348. A bill to amend the Higher Education Act of 1965 to modify the computation of eligibility for certain Federal Pell Grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Ms. CANTWELL. Mr. President, I come to the floor today to discuss a topic that I believe is critical to our Nation's economic growth and future competitiveness—the training of our workforce.

We are living in tough economic times. The economy of the State of Washington and the Nation at large are suffering through a recession where jobs are scarce and workers are scrambling to pay the bills. The most recent employment data available from the Bureau of Labor Statistics have offered little comfort in Washington where the unemployment rate is 7.3 percent. Washington, along with the other Pacific Northwest States of Oregon and Alaska, continues to have among the highest unemployment rates in the nation.

Just a month ago, the Senate moved quickly to extend the temporary extension of unemployment compensation program, so that approximately four million workers across this country will not lose their Federal extended unemployment benefits. I am proud that the Senate acted quickly to extend this important program. This means that over 100,000 unemployed workers in Washington State will receive 26 weeks of Federal extended benefits. I am disappointed, however, that we were not able to pass coverage for the estimated 1.1 million unemployed workers who have entirely exhausted their State and Federal benefits. Therefore, I am fighting to pass a bill that would extend coverage to the long-term unemployed, so that help is available to the hardest hit workers in this weak economy.

Nonetheless, our efforts should not stop with an unemployment insurance extension. We must continue to pursue long-term strategies for a sustained economic recovery. The fundamental strength of our economy lies in the working men and women of this Nation whose innovation and hard work propelled the massive economic expansion of the past decade.

The competitive edge that will keep our workers ahead in this changing global economy is their skills. Our economy is global, linked by international markets and communications networks. The sustained success of U.S. companies depends on adaptability and innovation, which means that workers themselves need to remain flexible and continually update job skills.

Even in this time of high unemployment, businesses throughout the country cannot find workers with the skills they need. According to a study completed by Heldrich Work Trends Survey, American employers are finding it difficult to hire qualified workers. Nearly half, 46 percent, of American businesses say they have had trouble finding workers with the necessary skills. At the same time, over three million workers are laid off each year, but well under 500,000 receive any sort of training to learn the skills demanded by those businesses that face worker shortages. Job training is an answer to meeting those skill demands and bridging the skills gaps that persist. However, it will not occur widely without a strong financial commitment from the Federal Government to ensure access to job training programs, and ongoing efforts to maximize the effectiveness of those funds that we already invest.

Investment in job training must be our first priority not our last—the decisions we make today to invest in our workers will pay off many times over in the form of stronger local economies, healthier communities, and improved quality of life.

But the reality is that we are delivering a trickle of funding while faced with a tidal wave of need. I have traveled across my state, from Olympia to Kelso, Vancouver to Bellingham, the Tri-cities to Spokane and received a great deal of feedback from Washingtonians who are seeking training, are providing it, or are serving as employers who need to hire skilled workers. And I heard similar concerns repeated in each of these areas: first, as our economy continues to evolve, the demand for new skills has grown; second, the enormous increase in demand for skills training by individual workers who are upgrading skills or changing jobs is a trend that appears to be widespread throughout the Nation; but third, far too many of those workers seeking access to training cannot get the training they need due to limited space at training institutions and the limited tuition assistance.

Last year, my office released a study of this apparent shortfall in capacity of training systems in my State, and the results of that study were staggering to me. There are over 110,000 dislocated workers in my state, the majority of whom want to upgrade their skills but cannot do so because of budgetary limitations that prevent institutions from offering enough courses, and the limited numbers of available training vouchers.

To make things worse, this year, the State of Washington received approximately 40 percent less in Workforce Investment Act, WIA, formula funding compared to last year. This drastic cut in WIA funding means that services will be cut back at a time when the demand is at an all time high. It is imperative that during this time of State deficits, States receive additional help from the Federal Government for important services such as education and job training.

As my colleagues know, the Workforce Investment Act is up for reauthorization this year. The WIA system is clearly the centerpiece of the Federal job training programs. It provides a one-stop delivery system designed to meet a broad range of worker needs, and it emerged from years of bipartisan work by Congress to consolidate over 33 Federal programs into one system for delivering employment and training services.

Today, I am introducing three bills that are designed to build upon the existing workforce structure to expand opportunities for training and improve its effectiveness.

The first piece of legislation would change the Pell Grant program to make certain that student financial aid is available to recently laid off workers. Under current law, the standard practice in the determination of Pell Grant eligibility for student aid is to base grant awards upon the applicant's income during the previous year. The use of tax forms for this purpose, in many cases, is the most appropriate and easiest administrative method of obtaining a clear and official statement of financial need. But, as a result, many recently laid-off workers are not eligible for critical financial assistance at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current-year income levels for applicants seeking training through Pell Grant-eligible programs. It does this in a very narrow way, by only allowing institutions in States with high unemployment rates to consider current year financial circumstances rather than previous year income.

The second bill addresses issues of distance-learning and delivery of training to hard to reach areas in a comprehensive manner. While many distance-learning technologies have been developed in recent years, those technologies have not necessarily reached many of those who are most in need of training. Many workers in need of

training may not be aware of online distance learning opportunities and may not be able to take advantage of them even if they do know about them. I believe, it is not enough to create a distance learning curriculum and passively provide it through an educational institution website. Rather, comprehensive solutions need to be developed that integrate curriculum innovations, technological access, and the promotion and linkage of workers in need of training with such opportunities, especially to help workers in rural areas. That's why my bill encourages the local workforce development boards to plan a comprehensive approach to improve access to and delivery of employment training services by using technology and online resources to connect workers with the information and tools they need to upgrade their skills.

The third bill that I am introducing today is designed to help local workforce development boards better understand regional labor market dynamics and improve system performance by identifying emerging sectors and industries with chronic worker shortages. My legislation encourages local workforce development boards to target employment and training resources so that workers can get training in occupations where employers need workers.

My legislation provides new resources to the state level so that states can direct funding down to the local workforce development boards to form partnerships with employers, unions, service providers and other key players in order to develop a strategic plan for addressing regional industry and workforce needs.

I want to make clear that this legislation is not intended to reinvent the wheel for areas that are already developing sectoral approaches within existing workforce development systems. In fact, Washington State is a leader in sector approaches: in 2000, the Washington State Legislature enacted legislation to support industry skills panels known as the ''Skills Initiative.'' The Skills Initiative provides grants to local workforce development councils to engage business and industry in strategies to close the skill gaps in my State. My legislation emphasizes this work by providing funding to support these partnerships.

This is a first step on a long journey as we work to improve Federal job training systems, and it is critical, now more than ever, that Congress increase funding for the job training programs under the Workforce Investment Act. By providing the necessary resources, we send a strong message to the American public that our government must invest in our greatest resource—the American worker. Each of these bills is an important component of that broader strategy, and I look forward to working with my colleagues as we begin to look at the reauthorization of WIA and the Higher Education Act this year and next.

Mr. President, I ask unanimous consent that the text of each bill be printed in the RECORD.

There being no objection, the bills were ordered to be printed in the RECORD, as follows:

S. 1346

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Sectoral Market Assessment for Regional Training Enhancement and Revitalization Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) More than ⅓ of the Nation's current workforce lacks the basic skills necessary to succeed in today's labor market.

(2) Globalization of the economy is leading to losses of jobs in key domestic industries, as well as challenges to competitiveness and productivity in other domestic industries.

(3) To remain economically vital and competitive, the Nation must invest in generating jobs and train a workforce skilled enough to contribute productively to the United States economy.

(4) Strategic planning that links workforce development and economic development, and the targeting of resources to industries that can build strong regional economies and create jobs with living wages for workers, need to be priorities for the workforce investment system.

(5) States and local workforce investment boards can play lead roles in guiding a more strategic process for achieving economic growth through workforce development.

SEC. 3. SKILLS GAP CAPACITY ENHANCEMENT GRANTS.

Subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.) is amended—

(1) by redesignating section 137 as section 138; and

(2) by inserting after section 136 the following:

''SEC. 137. SKILLS GAP CAPACITY ENHANCEMENT GRANTS.

''(a) PURPOSES.—The purposes of this section are—

''(1) to assist States and local boards in better focusing funds provided under this subtitle on activities and programs that address labor shortages and meet the emerging demand for skills in high-quality jobs in area industries;

''(2) to enhance the efficiency of the one-stop delivery systems and providers of training services;

''(3) to establish and improve partnerships between local boards, industry sectors, economic development agencies, providers of training services (including secondary schools, postsecondary educational institutions, community-based organizations, business associations, and providers of joint labor-management programs), providers of supportive services, and other related public and private entities;

''(4) to strengthen integration of workforce development strategies and economic development strategies in States, local areas, and labor markets;

''(5) to retain vital industries in the local areas and regions involved, avoid dislocation of workers, and strengthen the competitiveness of key industries; and

''(6) to encourage the development of career ladders and advancement efforts in local industries.

''(b) DEFINITIONS.—In this section:

''(1) CONSORTIUM.—The term 'consortium' means a consortium of local boards, established as described in subsection (d)(3).

''(2) REGION.—The term 'region' means 2 or more local areas that comprise a common labor market for an industry sector or group of related occupations.

''(3) TRAINING SERVICES.—The term 'training services' means services described in section 134(d)(4).

''(c) GRANTS TO STATES.—

''(1) IN GENERAL.—The Secretary shall make grants to States, to enable the States to assist local boards and consortia in carrying out the activities described in subsection (e).

''(2) FORMULA.—

''(A) IN GENERAL.—The Secretary shall make the grants in accordance with the formula used to make grants to States under section 132(b)(1)(B) (other than clause (iv)), subject to subparagraph (B).

''(B) SMALL STATE MINIMUM ALLOTMENT.—The Secretary shall ensure that no State shall receive an allotment under this paragraph for a fiscal year that is less than ½ of 1 percent of the funds made available to carry out this section for that fiscal year.

''(d) GRANTS TO LOCAL BOARDS.—

''(1) IN GENERAL.—A State that receives a grant under subsection (c)—

''(A) shall use the funds made available through the grant to make grants to local boards and consortia to carry out the activities described in subsection (e); and

''(B) may use not more than 15 percent of the funds made available through the grant, at the election of the State, to prepare strategic sectoral skills gap assessments, as described in subsection (e)(2), in the local areas or regions involved, or to provide technical assistance to local boards, consortia, or partnerships described in subsection (e)(3).

''(2) CONSIDERATION.—In making the grants, the State may take into account the size of the workforce in each local area or region.

''(3) CONSORTIA.—States shall encourage local boards to aggregate, to the maximum extent practicable, into consortia representing regions, for purposes of carrying out activities described in subsection (e). Nothing in this paragraph shall be construed to require local boards to aggregate into such consortia.

''(4) APPLICATIONS.—To be eligible to receive a grant under this section, a local board or consortium shall submit an application to the State, at such time and in such manner as the State may require, containing—

''(A) information identifying the members of the partnership described in subsection (e)(3) that will carry out the activities described in subsection (e); and

''(B) an assurance that the board or consortium will use, or ensure that the partnership uses, the funds to carry out the activities described in subsection (e).

''(e) USE OF FUNDS.—

''(1) IN GENERAL.—A local board or consortium that receives a grant under this section—

''(A) shall ensure that the partnership described in paragraph (3) uses the funds made available through the grant to—

''(i) prepare a strategic sectoral skills gap assessment, as described in paragraph (2), unless the State elects to prepare the assessment;

''(ii) develop a strategic skills gap action plan, as described in paragraph (4); and

''(iii) provide strategic training capacity enhancement seed grants to providers of training services specified in subsection (a)(3), one-stop operators, and other appropriate intermediaries, as described in paragraph (5); and

''(B) may use funds made available through the grant to ensure that activities carried

out under this subtitle are carried out in accordance with the strategic skills gap action plan.

''(2) STRATEGIC SECTORAL SKILLS GAP ASSESSMENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (E), the local board or consortium (or, at the election of the State, that State) shall prepare a strategic sectoral skills gap assessment, which shall—

''(i) identify areas of current and expected demand for labor and skills in a specific industry sector or group of related occupations that is—

''(I) producing high-quality jobs in the local area or region involved;

''(II) developing emerging jobs in that area or region; or

''(III) suffering chronic worker shortages;

''(ii) identify the current and expected supply of labor and skills in that sector or group in the local area or region; and

''(iii) identify gaps between the current and expected demand and supply of labor and skills in that sector or group in the local area or region.

''(B) SPECIFIC CONTENTS.—The assessment shall contain data regarding—

''(i)(I) specific high-quality employment opportunities offered by industries in the local area or region; and

''(II) specific skills desired for such opportunities;

''(ii)(I) occupations and positions in the local area or region that are difficult to fill; and

''(II) specific skills desired for such occupations and positions;

''(iii)(I) areas of growth and decline among industries and occupations in the local area or region; and

''(II) specific skills desired for such growth areas; and

''(iv) specific inventories of skills of unemployed or underemployed individuals in the local area or region.

''(C) INFORMATION.—The assessment shall contain current (as of the date of preparation of the assessment) information including specific information from multiple employers in the sector or group described in subparagraph (A)(i), labor organizations, and others connected to the businesses and workers in that sector or group, to illuminate local needs of both employers and workers. To the maximum extent possible, the information shall be regularly updated information.

''(D) SURVEY.—The assessment shall contain the results of a survey or focus group interviews of employers and labor organizations and other relevant individuals and organizations in the local area or region.

''(E) EXCEPTION.—

''(i) STATE.—A State shall not be required to use the funds made available through a grant received under this section, to prepare an assessment described in this paragraph.

''(ii) LOCAL BOARD OR CONSORTIUM.—A local board or consortium shall not be required to use the funds made available through a grant received under this section, to prepare an assessment described in this paragraph, if the local board or consortium demonstrates that, within the 2 years prior to receiving the grant, an assessment that meets the requirements of this paragraph has been prepared for the local area or region involved.

''(3) SKILLS PARTNERSHIP.—In carrying out this section, local boards and consortia shall enter into partnerships that include—

''(A) representatives of the local boards for the local area or region involved;

''(B) representatives of multiple employers for a specific industry sector or group of related occupations, and related sectors or occupations, identified through the assessment described in paragraph (2) as having identified gaps between the current and expected demand and supply of labor and skills in the industry sector or group of related occupations in the local area or region involved;

''(C) representatives of economic development agencies for the local area or region;

''(D) representatives of providers of training services described in subsection (a)(3) in the local area or region;

''(E) representatives nominated by State labor federations or local labor federations; and

''(F) other entities that can provide needed supportive services tailored to the needs of workers in the sector or group.

''(4) STRATEGIC SKILLS GAP ACTION PLAN.—The partnership shall develop a strategic skills gap action plan, based on the assessment, that—

''(A)(i) identifies specific barriers to adequate supply of labor and skills in demand in a specific industry sector or group of related occupations that is producing high-quality jobs in the local area or region involved; and

''(ii) identifies activities (which may include the provision of needed supportive services) that will remove or alleviate the barriers described in clause (i) that could be undertaken by one-stop operators and providers of training services described in subsection (a)(3);

''(B) specifies how the local board (or consortium) and economic development agencies in the partnership will integrate the board's or consortium's workforce development strategies with local or regional economic development strategies in that sector or group; and

''(C) identifies resources and strategies that will be used in the local area or region to address the skill gaps for both unemployed and incumbent workers in that sector or group.

''(5) STRATEGIC TRAINING CAPACITY ENHANCEMENT SEED GRANTS.—

''(A) IN GENERAL.—The local board or consortium, after consultation with the partnership, shall make grants to providers of training services described in subsection (a)(3), one-stop operators, and other appropriate intermediaries to pay for the Federal share of the cost of—

''(i) developing curricula to meet needs identified in the assessment described in paragraph (2) and to overcome barriers identified in the plan described in paragraph (4);

''(ii) modifying the programs of training services offered by the providers in order to meet those needs and overcome those barriers;

''(iii) operating pilot training efforts that demonstrate new curricula, or modifications to curricula, described in clause (i);

''(iv) expanding capacity of providers of training services in sectors or groups described in paragraph (2)(A)(i);

''(v) reorganizing service delivery systems to better serve the needs of employers and workers in the sectors or groups; or

''(vi) developing business services to ensure retention and greater competitiveness of the sectors or groups.

''(B) FEDERAL SHARE.—

''(i) IN GENERAL.—The Federal share of the cost described in subparagraph (A) shall be 75 percent.

''(ii) NON-FEDERAL SHARE.—The non-Federal share of the cost may be provided in cash or in kind, fairly evaluated, including plant, equipment, or services.''.

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

Section 138 of the Workforce Investment Act of 1998 (29 U.S.C. 2872), as redesignated by section 3(1), is amended by adding at the end the following:

''(d) SKILLS GAP CAPACITY ENHANCEMENT GRANTS.—In addition to any amounts authorized to be appropriated under subsection (a), (b), or (c), there are authorized to be appropriated to carry out section 137 such sums as may be necessary for fiscal years 2004 through 2007.''.

SEC. 5. CONFORMING AMENDMENTS.

(a) TABLE OF CONTENTS.—The table of contents in section 1(b) of the Workforce Investment Act of 1998 is amended by striking the item relating to section 137 and inserting the following:

''Sec. 137. Skills gap capacity enhancement grants.

''Sec. 138. Authorization of appropriations.''.

(b) REFERENCES TO AUTHORIZATION OF APPROPRIATIONS.—

(1) YOUTH ACTIVITIES.—Subsections (a) and (b)(1) of section 127 of the Workforce Investment Act of 1998 (29 U.S.C. 2852) are amended by striking ''section 137(a)'' each place it appears and inserting ''section 138(a)''.

(2) ADULT EMPLOYMENT AND TRAINING ACTIVITIES.—Section 132(a)(1) of the Workforce Investment Act of 1998 (29 U.S.C. 2862(a)(1)) is amended by striking ''section 137(b)'' and inserting ''section 138(b)''.

(3) DISLOCATED WORKER EMPLOYMENT AND TRAINING ACTIVITIES.—Subsections (a)(2) and (b)(2)(A)(i) of section 132 of the Workforce Investment Act of 1998 (29 U.S.C. 2862) are amended by striking ''section 137(c)'' each place it appears and inserting ''section 138(c)''.

S. 1347

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TRAINING SERVICE AND DELIVERY INNOVATION PROJECTS.

Section 171(b)(1)(D) of the Workforce Investment Act of 1998 (29 U.S.C. 2916(b)(1)(D)) is amended to read as follows:

''(D) targeted innovation projects that improve access to and delivery of employment and training services, with emphasis given to projects that incorporate advanced technologies to facilitate the connection of individuals to the information and tools they need to upgrade skills, including projects that link individuals in need of training to opportunities for self-guided learning, and with priority given to projects that—

''(i) actively promote sources of information about training opportunities and training content by providing technology directly to eligible training recipients;

''(ii) provide for the conduct of online eligibility determinations for Federal and State training programs, and direct individuals to the appropriate programs in the area; and

''(iii) integrate high-quality employment and training services information with the delivery of information regarding other social services and health care programs;''.

S. 1348

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Federal Pell Grant Eligibility Clarification Act of 2003''.

SEC. 2. CONSIDERATION OF CURRENT YEAR CIRCUMSTANCES.

Section 480(a) of the Higher Education Act of 1965 (20 U.S.C. 1087vv(a)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

(2) by adding at the end the following:

''(3) CONSIDERATION OF CURRENT YEAR CIRCUMSTANCES FOR CERTAIN PELL GRANT AWARDS.—

''(A) IN GENERAL.—If a student is a resident of a State that is in an extended benefit period (within the meaning of section 203 of the

Temporary Extended Unemployment Compensation Act of 2002 (Public Law 107–147)), then for purposes of calculating total income under paragraph (1) for a student seeking assistance under subpart 1 of part A, the Secretary shall reduce the student's total income by an amount by which—

''(i) the adjusted gross income plus untaxed income and benefits for the preceding tax year minus excludable income (as defined in subsection (e)), exceeds

''(ii) the projected gross income plus untaxed income and benefits for the current tax year minus the projected excludable income (as defined in subsection (e)).

''(B) ANTI-FRAUD PROCEDURES.—The Secretary shall establish procedures to ensure that computations made pursuant to subparagraph (A) are not fraudulent.''.

By Mr. SMITH (for himself, Mr. KOHL, Mrs. BOXER, Mr. CORNYN, Mr. FEINGOLD, Mrs. HUTCHISON, Ms. MURKOWSKI, and Mr. WYDEN):

S. 1349. A bill to amend the Internal Revenue Code of 1986 with respect to the eligibility of veterans for mortgage bond financing, and for other purposes; to the Committee on Finance.

Mr. SMITH. Mr. President, on behalf of myself and my colleagues, Mr. KOHL of Wisconsin, Mrs. BOXER of California, Mr. CORNYN of Texas, Mr. FEINGOLD of Wisconsin, Mrs. HUTCHISON of Texas, Ms. MURKOWSKI of Alaska, and Mr. WYDEN of Oregon, I ask unanimous consent that the text of the bill, the ''Veterans American Dream Home Ownership Act'' be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1349

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ALL VETERANS ELIGIBLE FOR STATE HOME LOAN PROGRAMS FUNDED BY QUALIFIED VETERANS' MORTGAGE BONDS.

(a) IN GENERAL.—Section 143(l)(4) of the Internal Revenue Code of 1986 (defining qualified veteran) is amended—

(1) by striking ''at some time before January 1, 1977'' in subparagraph (A), and

(2) by striking subparagraph (B) and inserting the following:

''(B) who applied for the financing before the date 30 years after the last on which such veteran left active service.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to financing provided and mortgage credit certificates issued after June 30, 2003.

SEC. 2. REVISION OF STATE VETERANS LIMIT.

(a) IN GENERAL.—Subparagraph (B) of section 143(l)(3) of the Internal Revenue Code of 1986 (relating to volume limitation) is amended to read as follows:

''(B) STATE VETERANS LIMIT.—A State veterans limit for any calendar year is the amount equal to—

''(i) $425,000,000 for the State of Texas,

''(ii) $537,000,000 for the State of California,

''(iii) $200,000,000 for the State of Oregon,

''(iv) $200,000,000 for the State of Wisconsin, and

''(v) $200,000,000 for the State of Alaska.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to bonds issued after December 31, 2003.

SEC. 3. ELECTIVE CARRYFORWARD OF UNUSED LIMITATION.

(a) IN GENERAL.—Section 143(l)(3) of the Internal Revenue Code of 1986 (relating to volume limitation) is amended by adding at the end the following:

''(D) ELECTIVE CARRYFORWARD OF UNUSED LIMITATION.—

''(i) IN GENERAL.—If—

''(I) a State veterans limit for any calendar year after 2002, exceeds

''(II) the aggregate amount of qualified veterans' mortgage bonds issued by such State,

such State may irrevocably elect to treat such excess as a carryforward for qualified veterans' mortgage bonds.

''(ii) USE OF CARRYFORWARD.—

''(I) IN GENERAL.—If a State elects a carryforward under clause (i), qualified veterans' mortgage bonds issued during the 3 calendar years following the calendar year in which the carryforward arose shall not be taken into account under subparagraph (A) to the extent the amount of such bonds does not exceed the amount of the carryforward so elected.

''(II) ORDER IN WHICH CARRYFORWARD USED.—Carryforwards elected shall be used in the order of the calendar years in which such carryforwards arose.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to bonds issued and carryforward elections made after December 31, 2003.

By Mrs. FEINSTEIN:

S 1350. A bill to require Federal agencies, and persons engaged in interstate commerce, in possession of electronic data containing personal information, to disclose any unauthorized acquisition of such information; to the Committee on the Judiciary.

Mrs. FEINSTEIN. Mr. President, I rise to introduce the Notification of Risk to Personal Data Act of 2003. This legislation will require that individuals are notified when their most sensitive personal information is stolen from a corporate or government database.

Specifically, the bill would require government or private entities to notify individuals if a data breach has compromised their Social Security number, driver's license number, credit card number, debit card number, or financial account numbers.

In most cases, if authorities know that someone is a victim of a crime, the victim is notified. But that isn't the case if an individual's most sensitive personal information is stolen from an electronic database.

Unfortunately, data breaches are becoming all too common. Consider the following incidents which have compromised the records of hundreds of thousands of Americans.

On April 5, 2002, a hacker broke into the electronic records of Steven P. Teale Data Center, the payroll facility for California State employees. The hacker compromises files containing the first initials, middle initials, and last names, Social Security numbers, and payroll deduction information of approximately 265,000 people. Despite the breathtaking potential harm of the crime, the breach was not publicly acknowledged and State employees were not made aware of their vulnerability to identify theft until May 24, 2002—17 days later.

On December 14, 2002, TriWest Health Care Alliance, a company that provides health care coverage for military personnel and their families, was burglarized at its Phoenix, AZ offices. Thieves broke into a management suite and stole laptop computers and computer hard drives containing the names, addressed, telephone numbers, birth dates and Social Security numbers of 562,000 military service members, dependents and retirees, as well as medical claims records for people on active duty in the Persian Gulf.

In February 2003, a hacker gained access to 10 million Visa, MasterCard, American Express Card and Discovery Card numbers from the databases of a credit processor, DPI Merchant services of Omaha, NE. Company officials maintained that the intruder did not obtain any personal information for these card numbers such as the account holder's name, address, telephone number or Social Security number. However, at least one bank canceled and replaced 8,800 cards when it found out about the security breach.

And in March of this year, a University of Texas student was charged with hacking into the university's computer system and stealing 55,000 Social Security numbers.

These are just some examples of the types of breaches that are occurring today. Except for California, which as a notification law going into effect in July, no State of Federal law requires companies or agencies to tell individuals of the misappropriation of their personal data.

I strongly believe Americans should be notified if a hacker gets access to their most personal data. This is both a matter of principle and a practical measure to curb identity theft.

Let me take a moment to describe the proposed legislation.

The Notification of Risk to Personal Data Act will set a national standard for notification of consumers when a data breach occurs.

Specifically, the legislation requires a business or government entity to notify an individual when there is a reasonable basis to conclude that a hacker or other criminal has obtained unencrypted personal data maintained by the entity.

Personal data is defined by the bill as an individual's Social Security number, State identification number, driver's license number, financial account number, or credit card number.

The legislation's notification scheme minimizes the burdens on companies or agencies that must report a data breach.

In general, notice would have to be provided to each person whose data was compromised in writing or through e-mail. But there are important exceptions.

First, companies that have developed their own reasonable notification policies are given a safe harbor under the

bill and are exempted from its notification requirements.

Second, encrypted data is exempted.

Third, where it is too expensive or impractical, e.g., contact address information is incomplete, to notify every individual who is harmed, the bill allows entities to send out an alternative form of notice called ''substitute notice.'' Substitute notice includes posting notice on a website or notifying major media.

Substitute notice would be triggered if any of the following factors exist: 1. the agency or person demonstrates that the cost of providing direct notice would exceed $250,000; 2. the affected class of subject persons to be notified exceeds 500,000; or 3. the agency or person does not have sufficient contact information to notify people whose information is at risk.

The bill has a tough, but fair enforcement regime. Entities that fail to comply with the bill will be subject to fines by the Federal Trade Commission of $5,000 per violation or up to $25,000 per day while the violation persists. State Attorneys General can also file suit to enforce the statute.

Additionally, the bill would allow California's new law to remain in effect, but preempt conflicting State laws. It is my understanding that legislators in a number of States are developing bills modeled after the California law. Reportedly, some of these bills have requirements that are inconsistent with the California legislation. It is not fair to put companies in a situation that forces them to comply with database notification laws of 50 different States.

I strongly believe individuals have a right to be notified when their most sensitive information is compromised—because it is truly their information. Ask the ordinary person on the street if he or she would like to know if a criminal had illegally gained access to their personal information from a database—the answer will be a resounding yes.

Enabling consumers to be notified in a timely manner of security breaches involving their personal data will help combat the growth scourge of identity theft. According to the Identity Theft Resources Center, a typical identity theft victim takes six to 12 months to discover that a fraud has been perpetuated against them.

As Linda Foley, Executive Director of the Identity Theft Resources center puts it: ''Identity theft is a crime of opportunity and time is essential at every junction. Every minute that passes after the breach until detection and notification increases the damage done to the consumer victim, the commercial entities, and law enforcement's ability to track and catch the criminals. It takes less than a minute to fill out a credit application and to start an action that could permanently affect the victim's life. Multiply that times hundreds of minutes, hundreds of opportunities to use or sell the information stolen and you just begin to understand the enormity of the problem that the lack of notification can cause.''

If individuals are informed of the theft of their Social Security numbers or other sensitive information, they can take immediate preventative action.

They can place a fraud alert on their credit report to prevent crooks from obtaining credit cards in their name; they can monitor their credit reports to see if unauthorized activity has occurred; they can cancel any affected financial or consumer or utility accounts; they can change their phone numbers if necessary.

I look forward to working with my colleagues to pass this vitally needed legislation. This bill will give ordinary Americans more control and confidence about the safety of their personal information. Americans will have the security of knowing that should a breach occur, they will be notified and be able to take protective action.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1350

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Notification of Risk to Personal Data Act''.

SEC. 2. DEFINITIONS.

In this Act, the following definitions shall apply:

(1) AGENCY.—The term ''agency'' has the same meaning given such term in section 551(1) of title 5, United States Code.

(2) BREACH OF SECURITY OF THE SYSTEM.—The term ''breach of security of the system''—

(A) means the compromise of the security, confidentiality, or integrity of computerized data that results in, or there is a reasonable basis to conclude has resulted in, the unauthorized acquisition of and access to personal information maintained by the person or business; and

(B) does not include good faith acquisition of personal information by an employee or agent of the person or business for the purposes of the person or business, if the personal information is not used or subject to further unauthorized disclosure.

(3) PERSON.—The term ''person'' has the same meaning given such term in section 551(2) of title 5, United States Code.

(4) PERSONAL INFORMATION.—The term ''personal information'' means an individual's last name in combination with any 1 or more of the following data elements, when either the name or the data elements are not encrypted:

(A) Social security number.

(B) Driver's license number or State identification number.

(C) Account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account.

(5) SUBSTITUTE NOTICE.—The term ''substitute notice'' means—

(A) e-mail notice, if the agency or person has an e-mail address for the subject persons;

(B) conspicuous posting of the notice on the Internet site of the agency or person, if the agency or person maintains an Internet site; or

(C) notification to major media.

SEC. 3. DATABASE SECURITY.

(a) DISCLOSURE OF SECURITY BREACH.—

(1) IN GENERAL.—Any agency, or person engaged in interstate commerce, that owns or licenses electronic data containing personal information shall, following the discovery of a breach of security of the system containing such data, notify any resident of the United States whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person.

(2) NOTIFICATION OF OWNER OR LICENSEE.—Any agency, or person engaged in interstate commerce, in possession of electronic data containing personal information that the agency does not own or license shall notify the owner or licensee of the information if the personal information was, or is reasonably believed to have been, acquired by an unauthorized person through a breach of security of the system containing such data.

(3) TIMELINESS OF NOTIFICATION.—Except as provided in paragraph (4), all notifications required under paragraph (1) or (2) shall be made as expediently as possible and without unreasonable delay following—

(A) the discovery by the agency or person of a breach of security of the system; and

(B) any measures necessary to determine the scope of the breach, prevent further disclosures, and restore the reasonable integrity of the data system.

(4) DELAY OF NOTIFICATION AUTHORIZED FOR LAW ENFORCEMENT PURPOSES.—If a law enforcement agency determines that the notification required under this subsection would impede a criminal investigation, such notification may be delayed until such law enforcement agency determines that the notification will no longer compromise such investigation.

(5) METHODS OF NOTICE.—An agency, or person engaged in interstate commerce, shall be in compliance with this subsection if it provides the resident, owner, or licensee, as appropriate, with—

(A) written notification;

(B) e-mail notice, if the person or business has an e-mail address for the subject person; or

(C) substitute notice, if—

(i) the agency or person demonstrates that the cost of providing direct notice would exceed $250,000;

(ii) the affected class of subject persons to be notified exceeds 500,000; or

(iii) the agency or person does not have sufficient contact information for those to be notified.

(6) ALTERNATIVE NOTIFICATION PROCEDURES.—Notwithstanding any other obligation under this subsection, an agency, or person engaged in interstate commerce, shall be deemed to be in compliance with this subsection if the agency or person—

(A) maintains its own reasonable notification procedures as part of an information security policy for the treatment of personal information; and

(B) notifies subject persons in accordance with its information security policy in the event of a breach of security of the system.

(7) REASONABLE NOTIFICATION PROCEDURES.—As used in paragraph (6), with respect to a breach of security of the system involving personal information described in section 2(4)(C), the term ''reasonable notification procedures'' means procedures that—

(A) use a security program reasonably designed to block unauthorized transactions before they are charged to the customer's account;

(B) provide for notice to be given by the owner or licensee of the database, or another party acting on behalf of such owner or licensee, after the security program indicates that the breach of security of the system has resulted in fraud or unauthorized transactions, but does not necessarily require notice in other circumstances; and

(C) are subject to examination for compliance with the requirements of this Act by 1 or more Federal functional regulators (as defined in section 509 of the Gramm-Leach Bliley Act (15 U.S.C. 6809)), with respect to the operation of the security program and the notification procedures.

(b) CIVIL REMEDIES.—

(1) PENALTIES.—Any agency, or person engaged in interstate commerce, that violates this section shall be subject to a fine of not more than $5,000 per violation, to a maximum of $25,000 per day while such violations persist.

(2) EQUITABLE RELIEF.—Any person engaged in interstate commerce that violates, proposes to violate, or has violated this section may be enjoined from further violations by a court of competent jurisdiction.

(3) OTHER RIGHTS AND REMEDIES.—The rights and remedies available under this subsection are cumulative and shall not affect any other rights and remedies available under law.

(c) ENFORCEMENT.—The Federal Trade Commission is authorized to enforce compliance with this section, including the assessment of fines under subsection (b)(1).

SEC. 4. ENFORCEMENT BY STATE ATTORNEYS GENERAL.

(a) IN GENERAL.—

(1) CIVIL ACTIONS.—In any case in which the attorney general of a State has reason to believe that an interest of the residents of that State has been or is threatened or adversely affected by the engagement of any person in a practice that is prohibited under this Act, the State, as parens patriae, may bring a civil action on behalf of the residents of the State in a district court of the United States of appropriate jurisdiction to—

(A) enjoin that practice;

(B) enforce compliance with this Act;

(C) obtain damage, restitution, or other compensation on behalf of residents of the State; or

(D) obtain such other relief as the court may consider to be appropriate.

(2) NOTICE.—

(A) IN GENERAL.—Before filing an action under paragraph (1), the attorney general of the State involved shall provide to the Attorney General—

(i) written notice of the action; and

(ii) a copy of the complaint for the action.

(B) EXEMPTION.—

(i) IN GENERAL.—Subparagraph (A) shall not apply with respect to the filing of an action by an attorney general of a State under this subsection, if the State attorney general determines that it is not feasible to provide the notice described in such subparagraph before the filing of the action.

(ii) NOTIFICATION.—In an action described in clause (i), the attorney general of a State shall provide notice and a copy of the complaint to the Attorney General at the time the State attorney general files the action.

(b) CONSTRUCTION.—For purposes of bringing any civil action under subsection (a), nothing in this Act shall be construed to prevent an attorney general of a State from exercising the powers conferred on such attorney general by the laws of that State to—

(1) conduct investigations;

(2) administer oaths or affirmations; or

(3) compel the attendance of witnesses or the production of documentary and other evidence.

(c) VENUE; SERVICE OF PROCESS.—

(1) VENUE.—Any action brought under subsection (a) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

(2) SERVICE OF PROCESS.—In an action brought under subsection (a), process may be served in any district in which the defendant—

(A) is an inhabitant; or

(B) may be found.

SEC. 5. EFFECT ON STATE LAW.

The provisions of this Act shall supersede any inconsistent provisions of law of any State or unit of local government relating to the notification of any resident of the United States of any breach of security of an electronic database containing such resident's personal information (as defined in this Act), except as provided under sections 1798.82 and 1798.29 of the California Civil Code.

SEC. 6. EFFECTIVE DATE.

This Act shall take effect on the expiration of the date which is 6 months after the date of enactment of this Act.

By Mr. FRIST:

S. 1351. A bill to amend the Tennessee Valley Authority Act of 1933 to modify provisions relating to the Board of Directors of the Tennessee Valley Authority, and for other purposes; to the Committee on Environment and Public Works.

Mr. FRIST. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1351

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CHANGE IN COMPOSITION, OPERATION, AND DUTIES OF THE BOARD OF DIRECTORS OF THE TENNESSEE VALLEY AUTHORITY.

(a) IN GENERAL.—The Tennessee Valley Authority Act of 1933 (16 U.S.C. 831 et seq.) is amended by striking section 2 and inserting the following:

"SEC. 2. MEMBERSHIP, OPERATION, AND DUTIES OF THE BOARD OF DIRECTORS.

''(a) MEMBERSHIP.—

''(1) APPOINTMENT.—The Board of Directors of the Corporation (referred to in this Act as the 'Board') shall be composed of 9 members appointed by the President by and with the advice and consent of the Senate, who shall be legal residents of the service area.

''(2) CHAIRMAN.—The members of the Board shall select 1 of the members to act as chairman of the Board.

''(b) QUALIFICATIONS.—

''(1) IN GENERAL.—To be eligible to be appointed as a member of the Board, an individual—

''(A) shall be a citizen of the United States;

''(B) shall have widely recognized experience or applicable expertise in the management of or decisionmaking for a large corporate structure;

''(C) shall not be an employee of the Corporation;

''(D) shall have no substantial direct financial interest in—

''(i) any public-utility corporation engaged in the business of distributing and selling power to the public; or

''(ii) any business that may be adversely affected by the success of the Corporation as a producer of electric power; and

''(E) shall profess a belief in the feasibility and wisdom of this Act.

''(2) PARTY AFFILIATION.—Not more than 5 of the 9 members of the Board may be affiliated with a single political party.

''(c) RECOMMENDATIONS.—In appointing members of the Board, the President shall—

''(1) consider recommendations from such public officials as—

''(A) the Governors of States in the service area;

''(B) individual citizens;

''(C) business, industrial, labor, electric power distribution, environmental, civic, and service organizations; and

''(D) the congressional delegations of the States in the service area; and

''(2) seek qualified members from among persons who reflect the diversity and needs of the service area of the Corporation.

''(d) TERMS.—

''(1) IN GENERAL.—A member of the Board shall serve a term of 5 years, except that in first making appointments after the date of enactment of this paragraph, the President shall appoint—

''(A) 2 members to a term of 2 years;

''(B) 1 member to a term of 3 years; and

''(C) 2 members to a term of 4 years.

''(2) VACANCIES.—A member appointed to fill a vacancy in the Board occurring before the expiration of the term for which the predecessor of the member was appointed shall be appointed for the remainder of that term.

''(3) REAPPOINTMENT.—

''(A) IN GENERAL.—A member of the Board that was appointed for a full term may be reappointed for 1 additional term.

''(B) APPOINTMENT TO FILL VACANCY.—For the purpose of subparagraph (A), a member appointed to serve the remainder of the term of a vacating member for a period of more than 2 years shall be considered to have been appointed for a full term.

''(e) QUORUM.—

''(1) IN GENERAL.—Six members of the Board shall constitute a quorum for the transaction of business.

''(2) MINIMUM NUMBER OF MEMBERS.—A vacancy in the Board shall not impair the power of the Board to act, so long as there are 6 members in office.

''(f) COMPENSATION.—

''(1) IN GENERAL.—A member of the Board shall be entitled to receive—

''(A)(i) a stipend of $30,000 per year; plus

''(ii) compensation, not to exceed $10,000 for any year, at a rate that does not exceed the daily equivalent of the annual rate of basic pay prescribed under level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day the member is engaged in the actual performance of duties as a member of the Board at meetings or hearings; and

''(B) travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in Government service under section 5703 of title 5, United States Code.

''(2) ADJUSTMENTS IN STIPENDS.—The amount of the stipend under paragraph (1)(A)(i) shall be adjusted by the same percentage, at the same time and manner, and subject to the same limitations as are applicable to adjustments under section 5318 of title 5, United States Code.

''(g) DUTIES.—

''(1) IN GENERAL.—The Board shall—

''(A) establish the broad goals, objectives, and policies of the Corporation that are appropriate to carry out this Act;

''(B) develop long-range plans to guide the Corporation in achieving the goals, objectives, and policies of the Corporation and provide assistance to the chief executive officer to achieve those goals, objectives, and policies, including preparing the Corporation

for fundamental changes in the electric utilities industry;

''(C) ensure that those goals, objectives, and policies are achieved;

''(D) approve an annual budget for the Corporation;

''(E) establish a compensation plan for employees of the Corporation in accordance with subsection (i);

''(F) approve the salaries, benefits, and incentives for managers and technical personnel that report directly to the chief executive officer;

''(G) ensure that all activities of the Corporation are carried out in compliance with applicable law;

''(H) create an audit committee, composed solely of Board members independent of the management of the Corporation, which shall—

''(i) recommend to the Board an external auditor;

''(ii) receive and review reports from the external auditor; and

''(iii) make such recommendations to the Board as the audit committee considers necessary;

''(I) create such other committees of Board members as the Board considers to be appropriate;

''(J) conduct public hearings on issues that could have a substantial effect on—

''(i) the electric ratepayers in the service area; or

''(ii) the economic, environmental, social, or physical well-being of the people of the service area; and

''(K) establish the electricity rate schedule.

''(2) MEETINGS.—The Board shall meet at least 4 times each year.

''(h) CHIEF EXECUTIVE OFFICER.—

''(1) APPOINTMENT.—The Board shall appoint a person to serve as chief executive officer of the Corporation.

''(2) QUALIFICATIONS.—To serve as chief executive officer of the Corporation, a person—

''(A) shall be a citizen of the United States;

''(B) shall have management experience in large, complex organizations;

''(C) shall not be a current member of the Board or have served as a member of the Board within 2 years before being appointed chief executive officer; and

''(D) shall have no substantial direct financial interest in—

''(i) any public-utility corporation engaged in the business of distributing and selling power to the public; or

''(ii) any business that may be adversely affected by the success of the Corporation as a producer of electric power; and

''(3) TENURE.—The chief executive officer shall serve at the pleasure of the Board.

''(i) COMPENSATION PLAN.—

''(1) IN GENERAL.—The Board shall approve a compensation plan that specifies salaries, benefits, and incentives for the chief executive officer and employees of the Corporation.

''(2) ANNUAL SURVEY.—The compensation plan shall be based on an annual survey of the prevailing salaries, benefits, and incentives for similar work in private industry, including engineering and electric utility companies, publicly owned electric utilities, and Federal, State, and local governments.

''(3) CONSIDERATIONS.—The compensation plan shall provide that education, experience, level of responsibility, geographic differences, and retention and recruitment needs will be taken into account in determining salaries of employees.

''(4) SUBMISSION TO CONGRESS.—No salary shall be established under a compensation plan until after the compensation plan and the survey on which it is based have been submitted to Congress and made available to the public for a period of 30 days.

''(5) POSITIONS AT OR BELOW LEVEL IV.—The chief executive officer shall determine the salary and benefits of employees whose annual salary is not greater than the annual rate payable for positions at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) POSITIONS ABOVE LEVEL IV.—On the recommendation of the chief executive officer, the Board shall approve the salaries of employees whose annual salaries would be in excess of the annual rate payable for positions at level IV of the Executive Schedule under section 5315 of title 5, United States Code.''.

(b) CURRENT BOARD MEMBERS.—A member of the board of directors of the Tennessee Valley Authority who was appointed before the effective date of the amendment made by subsection (a)—

(1) shall continue to serve as a member until the date of expiration of the member's current term; and

(2) may not be reappointed.

SEC. 2. CHANGE IN MANNER OF APPOINTMENT OF STAFF.

Section 3 of the Tennessee Valley Authority Act of 1933 (16 U.S.C. 831b) is amended—

(1) by striking the first undesignated paragraph and inserting the following:

''(a) APPOINTMENT BY THE CHIEF EXECUTIVE OFFICER.—The chief executive officer shall appoint, with the advice and consent of the Board, and without regard to the provisions of the civil service laws applicable to officers and employees of the United States, such managers, assistant managers, officers, employees, attorneys, and agents as are necessary for the transaction of the business of the Corporation.''; and

(2) by striking ''All contracts'' and inserting the following:

''(b) WAGE RATES.—All contracts''.

SEC. 3. CONFORMING AMENDMENTS.

(a) The Tennessee Valley Authority Act of 1933 (16 U.S.C. 831 et seq.) is amended—

(1) by striking ''board of directors'' each place it appears and inserting ''Board of Directors''; and

(2) by striking ''board'' each place it appears and inserting ''Board''.

(b) Section 9 of the Tennessee Valley Authority Act of 1933 (16 U.S.C. 831h) is amended—

(1) by striking ''The Comptroller General of the United States shall audit'' and inserting the following:

''(c) AUDITS.—The Comptroller General of the United States shall audit''; and

(2) by striking ''The Corporation shall determine'' and inserting the following:

''(d) ADMINISTRATIVE ACCOUNTS AND BUSINESS DOCUMENTS.—The Corporation shall determine''.

SEC. 4. EFFECTIVE DATE.

The amendments made by this Act take effect, and 7 additional members of the Board of Directors of the Tennessee Valley Authority shall be appointed so as to commence their terms on, the first date following the date of enactment of this Act on which the term of a member of the Board of Directors of the Tennessee Valley Authority expires.

By Mr. WYDEN (for himself and Mrs. FEINSTEIN):

S. 1352. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. WYDEN. Mr. President: Today, I introduce, for myself and Mrs. FEINSTEIN, the Community and Forest Protection Act. I ask unanimous consent that the text of the bill to be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

(a) FINDINGS.—Congress finds that:

(1) In 2002, approximately six and one half million acres of forest lands in the U.S. burned with varying degrees of severity, 21 people lost their lives, and over 3000 structures were destroyed. The Forest Service and Bureau of Land Management spent more than $1 billion fighting these fires.

(2) 73 million acres of public lands are classified as condition class 3 fire risks. This includes 23 million acres that are in strategic areas designated by the U.S. Forest Service for emergency treatment to withstand catastrophic fire.

(3) The forest management policy of fire suppression has resulted in an accumulation of fuel loads, dead and dying trees, and nonnative species that create fuel ladders which allow fires to reach the crowns of large old trees and cause catastrophic fire.

(4) The U.S. Forest Service and the Department of the Interior should immediately undertake an emergency program to reduce the risk of catastrophic fire.

(5) This emergency program should prioritize the protection of homes and communities and the restoration of forest health on lands at the highest risk of catastrophic fire. All fuel reduction treatments should protect old growth stands and large trees to ensure a rich and continued species diversity in the nation's forests.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Community and Forest Protection Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. HAZARDOUS FUELS REDUCTION PROJECTS.

(a) IN GENERAL.—The Secretaries of Agriculture and the Interior shall conduct immediately and to completion hazardous fuels reduction projects consistent with the Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risks to Communities and the Environment on an aggregate area of 20 million acres of federal land.

(1) These projects shall be conducted on the priority lands identified in subsection (d), using the expedited procedures in section 3.

(2) The Secretaries shall protect old growth stands and large trees pursuant to subsection (h).

(b) SELECTION OF PROJECTS.—The Secretaries of Agriculture and the Interior shall

jointly select hazardous fuels reduction projects identified by the Implementation Plan of the Comprehensive Strategy.

(c) CONSISTENCY WITH EXISTING FOREST MANAGEMENT PLANS AND ENVIRONMENTAL LAWS.—Any project carried out pursuant to this Act shall be consistent with the applicable forest plan, resource management plan, or other applicable agency plans or environmental laws except as specifically amended by this Act.

(d) PRIORITY LANDS.—In implementing projects under this Act, the Secretaries of Agriculture and the Interior shall give highest priority to:

(1) Wildland-urban interface: Condition class 3 or condition class 2 federal lands or, where appropriate, non-federal lands;

(2) Municipal watersheds: Condition class 3 federal lands located in such proximity to a municipal water supply system that a hazardous fuels reduction project must be carried out to reduce the risk of harm to such system resulting from wildfire;

(3) Fire Regime I lands: Federal lands that are condition class 3; and

(4) Fire Regimes II and III lands: Condition class 3 federal lands identified by the Secretary as an area where windthrow or blowdown, or the existence of disease or insect infestation, pose a significant threat to forest health or adjacent private lands.

(e) PUBLIC NOTICE AND PUBLIC RESPONSE.—

(1) QUARTERLY NOTICE.—The Secretary shall provide quarterly notice of each hazardous fuels reduction project which uses the streamlined processes established by this Act. The quarterly notice shall be provided for all projects in the Federal Register and on an agency website and in a local paper of record for local projects. The Secretary may combine this quarterly notice with other quarterly notices otherwise issued regarding federal forest management.

(2) CONTENT.—For each hazardous fuels reduction project for which the processes established by this Act are to be used the notice required by paragraph (1) shall include at a minimum:

(A) identification of each project as a hazardous fuels reduction project for which the processes established by this Act are to be used;

(B) a description of the project, including as much information on its geographic location as practicable;

(C) the approximate date on which scoping for the project will begin; and

(D) information regarding how interested members of the public can take part in the development of the project, including, but not limited to, project related public meeting notification.

(3) PUBLIC MEETING.—Following publication of each quarterly notice under paragraph (1), but before the beginning of scoping under section 3(a), the Secretary shall conduct a public meeting at an appropriate location in each administrative unit of the federal lands regarding those hazardous fuels reduction projects contained in the quarterly notice that are proposed to be conducted in that administrative unit. The Secretary shall provide advance notice of the date and time of the meeting in the quarterly notice or using the same means described in paragraph (1).

(4) PUBLIC RESPONSE TO NOTICE OF PROJECTS.—

(A) IN GENERAL.—A federally formed resource advisory committee may petition, with supporting evidence, the Secretary to better assess ground conditions of land to be covered by projects, during scoping or public comment on specific hazardous fuels reduction projects identified under subsection (b).

(B) PRIORITY LANDS INCLUDED IN THE PROJECTS.—For specific hazardous fuels reduction projects the petitioner may seek to correct the inclusion or exclusion of priority lands identified in subsection (d). The petitioner may also seek designation of large trees or old growth stands to be protected under subsection (h).

(C) SECRETARIAL RESPONSE.—The Secretary must respond to the petition within 30 days by. public notice by the same means described in paragraph (1). The Secretary shall provide a public viewing of the area in question if requested in the petition within 90 days of receipt. of the petition, with the petitioner and any other interested parties.

(D) DETERMINATION OF PETITION.—The Secretary must accept or deny the petition within 120 days of its receipt, based on site-specific review of historic ecological conditions, forest type, present fuel loads, and determination of whether the area properly qualifies as priority lands under subsection (d).

(5) FINAL AGENCY ACTION.—The Secretary shall provide notice by the same means described in paragraph (1) of any final agency action regarding a hazardous fuels reduction project for which the processes established by this Act are used.

(f) PRIORITY HAZARDOUS FUELS REDUCTION FUNDING.—The Secretaries shall expend no less than 70 percent of funds under this Act on projects within the wildland-urban interface, provided that the Secretaries may adjust this funding formula for a particular State at the request of its governor. In no event shall the Secretaries expend less than 50 percent or greater than 75 percent of funds within the wildland-urban interface for a particular State.

(g) MONITORING.—The Secretaries shall establish a multiparty monitoring process with representation from resource industries, environmentalists, independent scientists, community-based organizations, and other interested parties in order for Congress to assess a representative sampling of the hazardous fuels reduction projects implemented pursuant to this Act.

(h) LIMITATIONS.—In implementing hazardous fuels reduction projects under this Act the Secretary:

(1) shall not undertake any hazardous fuels reduction projects in wilderness study areas or components of the National Wilderness Preservation System;

(2) shall not construct new roads in inventoried roadless areas as part of any hazardous fuels reduction project;

(3) shall fully maintain the structure, function, processes and composition of structurally complex older forests (old growth) according to each ecosystem type; and

(4) outside old growth stands:

(A) shall focus on small diameter trees and thin from below to modify fire behavior as measured by rate of spread, height to live crown, and flame length; and

(B) shall maximize the retention of large trees to the extent that they promote fire-resistant stands and species diversity as appropriate for the forest type and site.

SEC. 3. EXPEDITED PROCESS.

(a) SCOPING.—The Secretary shall conduct scoping for each hazardous fuels reduction project implemented pursuant to this Act.

(b) CATEGORICAL EXCLUSIONS IN THE WILDLAND-URBAN INTERFACE.—

(1) IN GENERAL.—The wildland-urban interface hazardous fuels reduction projects authorized by this Act are conclusively determined to be categorically excluded from further analysis under the National Environmental Policy Act of 1969 (''NEPA''), 42 U.S.C. 4332, and the Secretary need not make any findings as to whether the projects individually or cumulatively have a significant effect on the environment.

(2) VARIED TREATMENTS.—The Secretary shall vary the treatments and avoid clear cuts inside the wildland-urban interface to ensure forest health. The Secretary shall also protect old growth and large trees pursuant to subsection 2(h).

(3) EXTRAORDINARY CIRCUMSTANCES EXCEPTION.—For all hazardous fuels reduction projects implemented pursuant to this subsection, if there are extraordinary circumstances, the Secretary shall follow agency procedures related to categorical exclusions and extraordinary circumstances. For the purposes of this subsection, a project's location within a municipal watershed shall not be considered an extraordinary circumstance.

(4) APPEALS.—No hazardous fuels reduction projects implemented pursuant to this subsection shall be subject to appeal requirements of the Appeals Reform Act (section 322 of Public Law 102–381) or the Department of the Interior Office of Hearings and Appeals.

(c) ENVIRONMENTAL ASSESSMENTS OUTSIDE THE WILDLAND-URBAN INTERFACE.—

(1) IN GENERAL.—For hazardous fuels reduction projects implemented pursuant to this Act on priority lands identified in section 2(d), if a categorical exclusion does not apply, the Secretary shall determine, consistent with NEPA, whether an environmental assessment is sufficient and use the procedures set forth in the Council on Environmental Quality ''Guidance for Environmental Assessments of Forest Health Projects,'' of December 9, 2002, or as amended.

(2) ISSUANCE OF DOCUMENTATION AND SHORTENED APPEALS.—Notwithstanding the Appeals Reform Act, section 322 of the Department of the Interior and Related Agencies Appropriations Act, 1993 (Public Law 102 381; 16 U.S.C. 1612 note), or regulations pertaining to the Department of the Interior Office of Hearings and Appeals procedures, for hazardous fuels reduction projects implemented by environmental assessments pursuant to subsection (c)(1):

(A) The Secretary may issue the environmental documentation and the decision document for the project simultaneously without public comment. Such issuance shall begin the administrative appeals process immediately.

(B) Persons must file any administrative appeal of projects under this subsection within 30 days after the date of issuance of a decision;

(C) The Secretary shall resolve any appeal not later than 30 days after the closing date for filing an appeal;

(D) If the review officer determines that an appeal has merit, in lieu of remanding the proposed agency action, the review officer, in consultation with the parties, may sign a new decision; and (E) The Secretary shall stay implementation of the project for 15 days beginning on the date on which the Secretary resolves any administrative appeal that complies with the requirements in subsection (d).

(d) STANDING TO APPEAL.—If a draft document prepared pursuant to NEPA for a hazardous fuels reduction project was available for public comment, or the project had scoping, the Secretary may require that a person filing an administrative appeal with respect to the project must have been involved in the public comment process for the project by submitting specific and substantive written comments with regard to the project or must have participated in the scoping of the project.

(e) SALVAGE MONITORING PILOT PROGRAM.—

(1) SALVAGE PILOT.—The Secretary is authorized to use the administrative appeals authorities under this subsection, pursuant to paragraph (2), for salvage hazardous fuels reduction projects in the area popularly known as the Biscuit Fire and reference on

the map entitled and dated _____ on file at the Forest Service _____ office.

(2) MONITORING.—The Secretary shall require that any salvage hazardous fuels reduction project on the Biscuit Fire be subject to ecological and economic monitoring of its effects, including on-site evaluation and inspections. The monitoring shall be conducted by a group with representation from independent scientists, industry representatives, environmentalists, community-based organizations, and other interested parties. Group selection shall be through the Western Governors Association Collaborative process. The group shall report to the public under section 2(e)(1) on the ecological and economic effects of individual salvage hazardous fuels projects.

SEC. 4. JUDICIAL REVIEW IN THE UNITED STATES DISTRICT COURTS.

(a) VENUE.—A hazardous fuels reduction project conducted under this Act shall be subject to judicial review only in the United States district court for the district in which the federal lands to be treated by the hazardous fuels reduction project are located, notwithstanding 28 U.S.C. 1391 or any other applicable venue statutes.

(b) EXPEDITIOUS COMPLETION OF JUDICIAL REVIEW.—Congress intends and encourages any court in which is filed a lawsuit or appeal of a lawsuit concerning an authorized hazardous fuels reduction project to expedite, to the maximum extent practicable, the proceedings in such lawsuit or appeal with the goal of rendering a final determination on jurisdiction, and if jurisdiction exists, a final determination on the merits, as soon as possible from the date the complaint or appeal is filed.

(c) DURATION OF INJUNCTION.—Any temporary injunctive relief granted regarding a project undertaken pursuant to this Act shall be limited to 60 days, with authority to renew each temporary injunction without limitation. For each injunctive renewal the parties shall present the court with updates on the status of the project.

(d) STANDARD OF REVIEW.—Nothing in this section shall change the standards of judicial review for any action concerning a project authorized under this Act.

SEC. 5. CONTRACTING.

(a) BEST VALUE CONTRACTING.—The Secretary shall use best value contracting criteria in awarding at least fifty percent of contracts and agreements for hazardous fuels reduction projects pursuant to this Act. Best value contract criteria will include, but not be limited to:

(1) the ability of the contractor to meet the ecological goals of the projects;

(2) the use of equipment that will minimize or eliminate impacts on soils; and (3) benefit to local economies in performing the restorative treatments and ensuring that wood byproducts are processed locally.

(b) MONITORING.—The Forest Service shall monitor the business and employment impacts of hazardous fuels reduction projects including the total dollar value of contracts and agreements awarded to qualifying entities.

(c) PUBLIC LANDS CORPS.—

(1) CONTRACTS AND AGREEMENTS.—

(A) IN GENERAL.—The Secretaries are authorized to enter into contracts or cooperative agreements with a Public Lands Corps

(i) to implement and complete projects prioritized in section 2(b) and (d) of this Act; and

(ii) to perform appropriate rehabilitation, enhancement, or beautification projects with the Department of Natural Resources, Department of Forestry or Department of Agriculture of any State.

(B) INDIAN LANDS.—Such projects may also be carried out on Indian lands with the approval of the relevant Indian tribe.

(C) PREFERENCE.—The Secretaries shall give preference to those projects which take place on lands identified as priorities in section 2(d) of this Act and can be planned and initiated promptly.

(D) SUPPORTIVE SERVICES.—The Secretaries are authorized to provide such services as the Secretaries deem necessary to carry out the purposes of this Act.

(E) TECHNICAL ASSISTANCE.—The Secretaries shall work with the National Association of Service and Conservation Corps to provide technical assistance, oversight, monitoring, and evaluation to the United States Departments of Agriculture and the Interior, State Departments of Natural Resources and Agriculture, and Public Lands Corps.

(2) NONDISPLACEMENT.—The nondisplacement requirements of Section 177 of the National and Community Service Trust Act of 1990 shall be applicable to all activities carried out under this Act by the Public Lands Corps.

(3) AUTHORIZATION OF APPROPRIATIONS.— For the purposes of this subsection there are authorized to be appropriated $12,500,000 annually for 5 years after the enactment of this Act.

(d) DEFINITIONS.— For the purposes of this section—

(1) CONTRACTS AND AGREEMENTS.—The term ''contracts and agreements'' means service contracts, timber sale contracts, construction contracts, supply contracts, emergency equipment rental agreements, architectural and engineering contracts, challenge cost-share agreements, cooperative agreements, and participating agreements.

(2) QUALIFYING ENTITY.—The term ''qualifying entity'' means—

(A) a natural-resource related small or micro-enterprise;

(B) a Youth Conservation Corps or Public Lands Corps crew or related partnership with State, local and other non-federal conservation corps;

(C) an entity that will hire and train local people to complete the contract or agreement;

(D) an entity that will re-train non-local traditional forest workers to complete the contract or agreement; or

(E) a local entity that meets the criteria to qualify for the Historically Underutilized Business Zone Program under section 32 of the Small Business Act (15 U.S.C. 657a).

(3) PUBLIC LANDS CORPS.—The term ''Public Lands Corps'' means any organization established by a state or local government, nonprofit organization, or Indian tribe that:

(A) has demonstrated the ability:

(i) to provide labor intensive productive work to individuals;

(ii) to recruit and train economically disadvantaged or at-risk youth;

(iii) to give participants a combination of work experience, basic and life skills, education, training and support services; and

(iv) to provide participants with the opportunity to develop citizenship values through service to their communities and the United States; and

(B) has also successfully completed, or is engaged in, a peer-reviewed, standards based program assessment process.

(4) STATE.—The term ''State'' means any State of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands of the United States, or the Commonwealth of the Northern Mariana Islands.

SEC. 6. BIOMASS GRANTS.

(a) DEFINITIONS.—For the purposes of this section:

(1) ELIGIBLE OPERATION.—The term ''eligible operation'' means a facility, that is located within the boundaries of an eligible community and uses biomass from federal or Tribal lands as a raw material to produce electric energy, sensible heat, transportation fuels, or substitutes for petroleum-based products.

(2) BIOMASS.—The term ''biomass'' means pre-commercial thinnings of trees and woody plants, or non-merchantable material, from hazardous fuels reduction projects.

(3) GREEN TON.—The term ''green ton'' means 2,000 pounds of biomass that has not been mechanically or artificially dried.

(4) ELIGIBLE COMMUNITY.—The term ''eligible community'' means any Indian Reservation, or any county, town, township, municipality, or other similar unit of local government that has a population of not more than 50,000 individuals and is determined by the Secretary to be located in an area near federal or Tribal lands which is at significant risk of catastrophic wildfire, disease, or insect infestation or which suffers from disease or insect infestation.

(5) INDIAN TRIBE.—The term ''Indian tribe'' has the meaning given the term in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)).

(b) BIOMASS COMMERCIAL UTILIZATION GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary may make grants to any individual, community, Indian tribe, small business or corporation, or nonprofit that owns or operates an eligible operation to offset capital expenses and costs incurred to purchase biomass for use by such eligible operation with priority given to operations using biomass from the highest risk areas.

(2) LIMITATION.—No grant provided under this subsection shall be paid at a rate that exceeds $20 per green ton of biomass delivered.

(3) RECORDS.—Each grant recipient shall keep such records as the Secretary may require to fully and correctly disclose the use of the grant funds and all transactions involved in the purchase of biomass. Upon notice by the Secretary, the grant recipient shall provide the Secretary reasonable access to examine the inventory and records of any eligible operation receiving grant funds.

(4) AUTHORIZATION OF APPROPRIATIONS.— For the purposes of this subsection, there are authorized to be appropriated $12,500,000 each to the Secretary of the Interior and the Secretary of Agriculture for each fiscal year for five years after the date of enactment of this Act.

(c) IMPROVED BIOMASS UTILIZATION PROGRAM.—

(1) IN GENERAL.—The Secretary may make grants to persons in eligible communities to offset the costs of developing or researching proposals to improve the use of biomass or add value to biomass utilization.

(2) SELECTION.—Grant recipients shall be selected based on the potential for the proposal to—

(A) develop affordable thermal or electric energy resources for the benefit of an eligible community;

(B) provide opportunities for the creation or expansion of small businesses within an eligible community;

(C) create new job opportunities within an eligible community, and

(D) reduce the hazardous fuels from the highest risk areas.

(3) LIMITATION.—No grant awarded under this subsection shall exceed $500,000.

(4) AUTHORIZATION OF APPROPRIATIONS.— For the purposes of this subsection, there are authorized to be appropriated $12,500,000 each to the Secretary of the Interior and the Secretary of Agriculture for each fiscal year for the five years after enactment of this Act.

(d) REPORT.—Not later than 3 years after the date of enactment of this Act, the Secretary of the Interior and the Secretary of

Agriculture shall jointly submit to the Congress a report that describes the interim results of the programs authorized under this section.

SEC. 7. FOREST STANDS INVENTORY AND MONITORING PROGRAM.

(a) IN GENERAL.—The Secretary of Agriculture and the Secretary of the Interior shall carry out, in conjunction with the National Aeronautics and Space Administration and other relevant agencies and research facilities (including the Forest Service Research Stations and academic institutions), a comprehensive program to inventory and assess forest stands on federal forest land and, with the consent of the owner, private forest land. The objective of this program shall be to evaluate current and future forest health conditions and address ecological impacts of insect, disease, invasive species, fire and weather-related episodic events. Emphasis shall be placed upon coordinating, reconciling, and field verification of existing data (including remotely sensed and modeled data utilized to characterize vegetation/cover types, density, fire regimes, fire effects, and condition classes), and improving the accuracy of such data to assist in management activities.

(b) LOCATION.—The facility for this program shall be located at the Ochoco National Forest Headquarters in Prineville, Oregon.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of this section, there are authorized to be appropriated $5,000,000 each fiscal year for the five years after enactment of this Act.

SEC. 8. EMERGENCY FUELS REDUCTION GRANTS.

(a) IN GENERAL.—The Secretary of Agriculture shall establish an Emergency Fuels Reduction Grant program to provide State and local agencies with financial assistance for hazardous fuels reduction projects addressing threats of catastrophic fire that have been determined by the United States Forest Service to pose a serious threat to human life.

(b) ELIGIBILITY.—Fuels reduction projects eligible for funding under the Emergency Fuels Reduction Grant program shall:

(1) be surrounded by or immediately adjacent to national forest boundaries;

(2) have been determined to be of paramount urgency by virtue of declarations of emergency by both local officials and the governor of the State in which they are located; and

(3) remove fuel loading determined to pose a serious threat to human life by the United States Forest Service.

(c) USE OF GRANT FUNDS.—Funds authorized under this section shall be limited to the following uses:

(1) removal of trees, shrubs or other potential fuels adjacent to primary evacuation routes;

(2) removal of trees, shrubs or other potential fuels adjacent to emergency response centers, emergency communication facilities or sites designated as shelter-in-place facilities; and

(3) evacuation drills and preparation.

(d) REVOLVING FUND.—For work done on private property and county lands, the grant recipients shall deposit into a revolving fund any proceeds from sale of the timber or biomass from the projects funded under this section. The revolving fund shall be used to assist with subsequent grants under this section.

(e) EMERGENCY FUELS REDUCTION GRANTS.—For the purposes of funding the Emergency Fuels Reduction Grant program under this Act, there are authorized to be appropriated to the Secretary of Agriculture $50,000,000 each fiscal year that this Act is in effect. Subject to section 13, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

SEC. 9. MARKET INCENTIVES FOR HOME PROTECTION.

It is the Sense of Congress that insurers should reduce premiums for homeowners in condition class 2 and condition class 3 areas within the wildland-urban interface who:

(1) clear brush and other flammable material in the vicinity of their homes;

(2) use non-flammable building materials for roofs and other critical structures; or

(3) otherwise improve the defensibility of their homes against catastrophic fire.

SEC. 10. ONGOING PROJECTS AND EXISTING AUTHORITIES.

Nothing in this Act shall affect projects begun prior to enactment of this Act or affect authorities otherwise granted to the Secretaries under existing law.

SEC. 11. PREFERENCE TO COMMUNITIES THAT HAVE ORDINANCES ON FIRE PREVENTION.

(a) IN GENERAL.—In determining the allocation of funding for the Community and Private Land Fire Assistance Program (16 USC 2106c/PL–171 Sec. 10A(b)), the Secretary shall prioritize funding to those communities which have taken proactive steps through the enactment of ordinances and other means, including those that have developed a comprehensive fire protection plan encompassing all ownerships, to encourage property owners to reduce fire risk on private property.

(b) PRIVATE LANDS.—Nothing in this Act shall affect existing authorities to use appropriations authorized by this Act to carry out the provisions under this Act on non-federal lands with the consent of the land owner.

SEC. 12. SUNSET.

The provisions of this Act shall expire five years after the date of enactment, except that projects for which a decision notice has been issued by that date may continue to be implemented.

SEC. 13. AUTHORIZATION OF APPROPRIATIONS.

(a) NATIONAL FOREST SYSTEM LANDS.—For the purposes of planning and conducting hazardous fuels reduction projects under this Act on National Forest System Lands, there are authorized to be appropriated to the Secretary of Agriculture $1,943,100,000 during the five-fiscal year period beginning October 1, 2003. Subject to section 12, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

(b) BLM LANDS.—For the purpose of planning and conducting hazardous fuels reduction projects under this Act on Federal lands managed by the Secretary of the Interior, there are authorized to be appropriated to the Secretary of the Interior $1,888,000,000 during the five-fiscal year period beginning October 1, 2003. Subject to section 12, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

SEC. 14. DEFINITIONS.

(a) LAND TYPES AND FIRE REGIME AREAS.—In this Act definitions of land types and fire regimes originate from the U.S. Forest Service Rocky Mountain Research Station, as follows—

(1) CONDITION CLASS 2.—The term ''condition class 2'' refers to lands on which—

(A) fire frequencies have been moderately altered and have departed from historic fire return frequencies (either increased or decreased) by one or more return interval, which results in moderate changes to fire size, frequency, intensity, severity or landscape patterns;

(B) there exists a moderate risk of losing key ecosystem components; and

(C) vegetation attributes have been moderately altered from their historic range.

(2) CONDITION CLASS 3.—The term ''condition class 3'' refers to lands on which—

(A) fire regimes have been significantly altered from their. historic range, which results in dramatic changes to fire size, frequency, intensity, severity, or landscape patterns;

(B) there exists a high risk of losing key ecosystem components; and

(C) vegetation attributes have been significantly altered from their historic range.

(3) FIRE REGIME I.—The term ''fire regime I'' refers to lands on which historically fire recurs in 0–35 year intervals and burns with low severity.

(4) FIRE REGIME II.—The term ''fire regime IP' refers to lands on which historically fire recurs in .0–35 year intervals and replaces existing vegetation.

(5) FIRE REGIME III.—The term ''fire regime III'' refers to lands on which historically fire recurs in 35–100 year intervals and burns with mixed severity.

(b) At-Risk Community.—The term ''at-risk community'' means a geographic area designated by the Secretary as any area—

(1) defined as an interface community in Volume 66, page 753, of the January 4, 2001 Federal Register;

(2) on which conditions are conducive to large-scale wildland fire disturbance events; and

(3) for which a significant threat to human life exists as a result of wildland fire disturbance events.

(c) BEST VALUE CONTRACTING.—The term ''best value contracting'' means the contracting process described in section 15.101 of title 48, Code of Federal Regulations, which allows the inclusion of non-cost factors in the federal contract process.

(d) COMPREHENSIVE STRATEGY.—The term ''Comprehensive Strategy'' means the Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risks to Communities and the Environment, dated May 2002, including by reference the related Implementation Plan, which was developed pursuant to the conference report to accompany the Department of Interior and Related Agencies Appropriations Act, 2001 (House Report 106–646).

(e) FEDERAL LANDS.—The term ''federal lands'' means National Forest System lands and public forested lands administered by the Secretary of the Interior acting through the Bureau of Land Management.

(f) GEOGRAPHIC FEATURE.—The term ''geographic feature'' means a ridge top, road, stream, or other landscape feature which can serve naturally as a firebreak, staging ground for firefighting, or boundary affecting fire behavior.

(g) HAZARDOUS FUELS REDUCTION PROJECT.—The term ''hazardous fuels reduction project'' means a project—

(1) undertaken for the purpose of reducing the amount of hazardous fuels resulting from alteration of a natural fire regime as a result of fire suppression or other management activities; and

(2) accomplished through the use of prescribed burning or mechanical treatment, or a combination thereof.

(h) INVENTORIED ROADLESS AREA.—The term ''inventoried roadless area'' means one of the areas identified in the set of inventoried roadless area maps contained in the Forest Service Roadless Areas Conservation, Final Environmental Impact Statement, Volume 2, dated November, 2000.

(i) LOCAL PREFERENCE CONTRACTING.—The term ''local preference contracting'' means the federal contracting process that gives preference to local businesses described in section 333 of the Department of Interior and

Related Agencies Appropriations Act, 2003 (division F of Public Law 108–7, 117 Stat. 277).

(j) MUNICIPAL WATER SUPPLY SYSTEM.—The term ''municipal water supply system'' means reservoirs, canals, ditches, flumes, laterals, pipes, pipelines, or other surface facilities and systems constructed or installed for the impoundment, storage, transportation, or distribution of drinking water for a community.

(k) SECRETARY.—The term ''Secretary'' means the Secretary of Agriculture, or the Secretary's designee, with respect to National Forest System lands; and the Secretary of the Interior, or the Secretary's designees, with respect to public lands administered by the Secretary through the Bureau of Land Management.

(l) WILDLAND-URBAN INTERFACE.—The term ''wildland-urban interface'' means the area either within an at-risk community or within the area.

(1) extending out to a geographic feature, if there is such a feature within approximately three-quarters of a mile of the community boundary; or

(2) if there is no such geographic feature, extending out one-half mile from the community boundary.

Mrs. FEINSTEIN. I rise to introduce with Senator WYDEN a bill to reduce the risk of catastrophic fire in our country's magnificent national forests.

No one who watched last week as Arizona's community of Summerhaven on Mount Lemmon burned can doubt the importance of this issue. My heart goes out to the residents of Summerhaven, and to the others who will be displaced by the fires yet to come this summer.

Americans know that there is something wrong with our national forests. For too long we have suppressed fires, gradually letting brush and small trees multiply until many of our forests are now choked by a dense thicket.

Today, there are 57 million acres of Federal lands at the highest risk of catastrophic forest fires. If we do not take action now, these forests could go up in smoke. This bill we are introducing today is balancing, and it will reduce the risk of catastrophic fire in our country's magnificent national forests.

This legislation would speed up the environmental review process—without sacrificing the most important environmental protections. It also would protect the communities which face the highest risk and safeguard old growth stands and large trees. And it would include sensible provisions on judicial review that will help projects go forward quickly without compromising our independent judiciary. These are provisions that makes sense, and I hope that my colleagues will support the bill.

We have crafted our bill around three fundamental principles:

We should focus limited Federal resources on protecting communities and on the forest lands truly most at risk;

We should speed up the environmental review process, but without sacrificing the most important environmental protections; and

We should protect old growth stands and large trees.

Let me show how the bill achieves these three goals.

First, the bill prioritizes our efforts. Many people believe that we should protect communities first. The bill does so. Seventy percent of the funding is directed to the wildland-urban interface near communities.

Of course, conditions vary by State. The bill allows Governors to adjust the percentage of work that is to be done within the wildland—urban interface for their State, up to a maximum of 75 percent, or down to a minimum of 50 percent.

By way of contrast, H.R. 1904, which passed the House, includes no focus on protecting communities. All the money can be spent far from communities under H.R. 1904, even if the Governor of a State wishes otherwise.

Senator WYDEN and I believe that in addition to protecting communities, there are some forest lands that should be thinned to ensure that catastrophic fires do not devastate the forest and eliminate habitat for the species that have there.

In the last century, Americans have rigorously suppressed fires, stamping them out whenever they start. In certain forests like ponderosa pine, these fires would naturally have cleared out the brush and small trees every 10 or 20 years or so.

In the absence of these fires, brush has grown into ''doghair thickets'' with dangerous levels of fuel loadings. When fires burn now in these forests, they will be so hot that they won't just clear out the brush but will kill the large trees and often scorch the soil.

These are the forests where we need to focus our efforts. We thus target thinning projects to forests that are both Fire Regime I and Condition Class 3. Fire Regime I forests are those that used to have low-intensity, brush-clearing fires; and Condition Class 3 forests are the most altered from their natural condition. The combination of Fire Regime I and Condition Class 3 are the highest priority lands for treatment.

We also direct projects to municipal watersheds and diseased or windblown forests that are in Condition Class 3. If we don't protect the municipal watersheds, catastrophic fires could strip off the tree cover that prevents soils from eroding into creeks and lakes. Municipalities' water quality could suffer.

In contrast to our bill, H.R. 1904 fails to prioritize brush-clearing projects for the areas that need it the most. Instead, H.R. 1904 provides expedited processes for lands that are only moderately altered by fire suppression—Condition Class 2 lands in addition to Condition Class 3.

In many of the forests where H.R. 1904 would direct brush-clearing work, there naturally would have been severe fires that burned all the trees in the stand. After a thinning project, fires in these forests will still behave the same way, scorching and killing most of the trees. Thus, much of the thinning called for in H.R. 1904 would have little effect on the fire behavior or forest health.

Senator WYDEN and I have worked very hard to develop a bill that speeds up the review process so important work can get done without sacrificing environmental protections.

Almost everyone agrees that we need to work quickly to protect the areas immediately around communities. There is little controversy or debate over these projects.

The Forest Service has proposed an analytical short-cut for these projects, which requires very little environmental analysis and no formal pubic comment process or administrative appeal.

There is some uncertainty, however, over the Forest Service's proposed approach. People can claim that laws Congress has previously passed will require some of these projects to be held up by more environmental analysis or administrative appeals.

Our bill eliminates this uncertainty. When the Forest Service works in the immediate vicinity of a community, the bill would make absolutely clear that there need to be no environmental analysis or administrative appeals. The only exception is where there might be extraordinary circumstances, such as a major threat to endangered species. We also prohibit the Forest Service from conducting clearcuts around communities, requiring them to focus on clearing out the brush.

By way of comparison, the House-passed bill does not provide any assistance to thinning projects in the immediate vicinity of communities, even though everyone agrees on the need for these projects.

Senator WYDEN and I have also sped up the process for projects outside the immediate vicinity of communities. These projects are more controversial, so we want to make sure that the public has some opportunity for input.

In the past, the Forest Service and the Department of the Interior have been able to conduct the majority of brush-clearing mechanical treatment following a National Environmental Policy Act process known as environmental assessments. Our bill simplified these environmental assessments in several ways.

The bill provides one round of public comment—the administrative appeal process—rather than two.

The bill shortens the time frame for administrative appeals from 90 to 60 days.

Finally, the appeal deciding offer can make necessary changes rather than having to send the project back to the original decisionmaker for further time-consuming review.

Together, these changes will likely speed up the process by a few months or more. We do all this without eliminating public comment or gutting core parts of the environmental analysis.

In contrast, the House-passed bill would eliminate the requirement that the Forest Service consider alternatives to the proposed project as part of its environmental analysis. In other

words, the Forest Service doesn't have to study other, less damaging ways of undertaking the project—it can just do the project the way it wants.

Many people think that public debate over alternatives is the core of the National Environmental Policy Act. Our bill does not eliminate this important environmental protection.

Another important part of our bill is its protection of magnificent old growth stands. The remaining groves of these trees provide a connection to nature untrammeled by human activity, a connection that many of us cherish.

Our bill would require full protection of these old growth stands. In addition, outside old growth stands, the bill focuses on small-diameter trees and protects large trees that promote fire-resistant stands and species diversity.

By way of contrast, H.R. 1904 provides no protection for these magnificent resources.

Let me now talk about judicial review. No one wants court cases to go on too long. In addition, people should not be able to tie up projects by gaming the system and picking and choosing the friendliest courts to hear their lawsuits.

Our bill addresses these problems. The bill encourages courts, to the maximum extent practicable, to resolve lawsuits over brush-clearing projects quickly. These are important projects for the safety of our communities and our forests, and it is appropriate to give them some priority.

In addition, we require that potential litigants file suit in the same judicial district where a fuels reduction project takes place, No one can game the system by looking for a friendly judge somewhere else.

Finally, we limit temporary injunctions that are typically issued at the outset of a case to 60 days. They can be renewed if necessary—but the challengers to a projects must submit updates explaining why the injunctions should be extended. This provision prevents projects from being held up any longer than is strictly necessary.

These changes will expedite the process—but they still respect our court system's essential autonomy. As a member of the Judiciary Committee, I spend much of my time trying to make sure our court system is as fair as possible.

Americans count on a judiciary independent of the executive branch to preserve their liberties and to right any wrongs that their government commits. I think it is very important that we do not interfere with the independence of our judiciary.

The House-passed bill would require the courts to give weight to certain findings by the Forest Service and the Department of the Interior. Even if projects had been found to violate the environmental laws, courts would be told to give weight to the agencies' findings and allow many of the projects to go ahead anyway.

This is a dangerous provision for a bill to include, and I cannot support it. I believe our bill includes more sensible provisions on judicial review that will help projects go forward quickly without compromising the independence of our judiciary.

Our bill includes several provisions to address forest health problems on private and State lands.

We authorize $50 million annually in emergency grants to States and localities where lives are at risk. The last few years have seen vast insect epidemics killing millions of trees in Southern California, Arizona, and elsewhere.

In places like Lake Arrowhead, Big Bear and Idyllwild in Southern California, communities are surrounded by dead and dying trees that are perfect kindling for a catastrophic fire. There is a real threat to people's lives that we must address.

There is now no good funding source for clearing evacuation routes and clearing around schools and other emergency shelters that are on State and private lands. The emergency grants in the bill would authorize funds for these essential purposes.

The bill also includes two measures to encourage homeowners to clear brush around their houses and install non-flammable roofs. A study of Southern California fires by Forest Service researcher Jack Cohen has shown that these measures could reduce a blaze's threat to homes by as much as 85 to 95 percent.

Our bill would encourage these homesaving practices in two ways:

The bill would prioritize grants to those communities that encourage brush-clearing and use of non-flammable roofs or develop comprehensive fire plans.

The bill would record the Sense of Congress that insurers should offer lower premiums to homeowners who take steps to protect their homes.

Our bill would also include grants to encourage the use of woody material, or biomass, for energy production. Biomass-to-energy plants serve multiple beneficial purposes: one, they are a clean and renewable source of energy; and two, they make brush-clearing projects more cost-effective, so we can protect more with the finite Federal dollars available.

Finally, our bill would also include contracting provisions to benefit rural communities. The Forest Service and the Department of the Interior would be required to use ''best value contracting'' for brush-clearing projects under the Act.

This contracting approach requires the agencies to consider other factors besides the price of the bid in awarding contractors. Bidders would be rewarded for such factors as their commitment to hire local workers, and their past record of environmental stewardship.

I would like to close by saying that this is truly a bipartisan issue. All of us, Democrat and Republican, have an interest in clearing out dangerous accumulations of brush in our national forests. All of us have an interest as well in protecting the magnificent old growth stands and species habitat that Americans cherish, and in upholding our environmental laws.

I look forward to working with my colleagues on both sides of the aisle to pass a bill as soon as possible.

By Mr. BROWNBACK (for himself and Mr. DEWINE):

S. 1353. A bill to establish new special immigrant categories; to the Committee on the Judiciary.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1353

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Widows and Orphans Act of 2003''.

SEC. 2. NEW SPECIAL IMMIGRANT CATEGORY.

(a) CERTAIN CHILDREN AND WOMEN AT RISK OF HARM.—Section 101(a)(27) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(27)) is amended—

(1) in subparagraph (L), by inserting a semicolon at the end;

(2) in subparagraph (M), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(N) subject to subsection (j), an immigrant who is not present in the United States—

''(i) who is—

''(I) referred to a consular, immigration, or other designated official by a United States Government agency, an international organization, or recognized nongovernmental entity designated by the Secretary of State for purposes of such referrals; and

''(II) determined by such official to be a minor under 10 years of age (as determined under subsection (j)(5))—

''(aa) for whom no parent or legal guardian is able to provide adequate care;

''(bb) who faces a credible fear of harm related to his or her age;

''(cc) who lacks adequate protection from such harm; and

''(dd) for whom it has been determined to be in his or her best interests to be admitted to the United States; or

''(ii) who is—

''(I) referred to a consular or immigration official by a United States Government agency, an international organization or recognized nongovernmental entity designated by the Secretary of State for purposes of such referrals; and

''(II) determined by such official to be a female who has—

''(aa) a credible fear of harm related to her sex; and

''(bb) a lack of adequate protection from such harm.''.

(b) STATUTORY CONSTRUCTION.—Section 101 of the Immigration and Nationality Act (8 U.S.C. 1101) is amended by adding at the end the following:

''(j)(1) No natural parent or prior adoptive parent of any alien provided special immigrant status under subsection (a)(27)(N)(i) shall thereafter, by virtue of such parentage, be accorded any right, privilege, or status under this Act.

''(2)(A) No alien who qualifies for a special immigrant visa under subsection

(a)(27)(N)(ii) may apply for derivative status or petition for any spouse who is represented by the alien as missing, deceased, or the source of harm at the time of the alien's application and admission. The Secretary of Homeland Security may waive this requirement for an alien who demonstrates that the alien's representations regarding the spouse were bona fide.

''(B) An alien who qualifies for a special immigrant visa under subsection (a)(27)(N) may apply for derivative status or petition for any sibling under the age of 10 years or children under the age of 10 years of any such alien, if accompanying or following to join the alien. For purposes of this subparagraph, a determination of age shall be made using the age of the alien on the date the petition is filed with the Department of Homeland Security.

''(3) An alien who qualifies for a special immigrant visa under subsection (a)(27)(N) shall be treated in the same manner as a refugee solely for purposes of section 412.

''(4) The provisions of paragraphs (4), (5), and (7)(A) of section 212(a) shall not be applicable to any alien seeking admission to the United States under subsection (a)(27)(N), and the Secretary of Homeland Security may waive any other provision of such section (other than paragraph 2(C) or subparagraph (A), (B), (C), or (E) of paragraph (3) with respect to such an alien for humanitarian purposes, to assure family unity, or when it is otherwise in the public interest. Any such waiver by the Secretary of Homeland Security shall be in writing and shall be granted only on an individual basis following an investigation. The Secretary of Homeland Security shall provide for the annual reporting to Congress of the number of waivers granted under this paragraph in the previous fiscal year and a summary of the reasons for granting such waivers.

''(5) For purposes of subsection (a)(27)(N)(i)(II), a determination of age shall be made using the age of the alien on the date on which the alien was referred to the consular, immigration, or other designated official.

''(6) The Secretary of Homeland Security shall waive any application fee for a special immigrant visa for an alien described in section 101(a)(27)(N).''.

(c) ALLOCATION OF SPECIAL IMMIGRANT VISAS.—Section 203(b)(4) of the Immigration Nationality Act (8 U.S.C. 1153(b)(4)) is amended by striking ''(A) or (B) thereof'' and inserting ''(A), (B), or (N) thereof''.

(d) EXPEDITED PROCESS.—Not later than 45 days from the date of referral to a consular, immigration, or other designated official as described in section 101(a)(27)(N) of the Immigration and Nationality Act, as added by subsection (a), special immigrant status shall be adjudicated and, if granted, the alien shall be paroled to the United States pursuant to section 212(d)(5) of that Act (8 U.S.C. 1182(d)(5)) and allowed to apply for adjustment of status to permanent residence under section 245 of that Act (8 U.S.C. 1255) within 1 year of the alien's arrival in the United States.

(e) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this section, the Secretary of Homeland Security shall report to the Committees on the Judiciary of the Senate and the House of Representatives on the progress of the program, including—

(1) data related to the implementation of this section;

(2) data regarding the number of placements of females and children at risk of harm as referred to in section 101(a)(27)(N) of the Immigration and Nationality Act, as added by subsection (a); and

(3) any other appropriate information that the Secretary of Homeland Security determines to be appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section and the amendments made by this section.

By Ms. MURKOWSKI (for herself and Mr. STEVENS):

S. 1354. A bill to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, I rise today to reintroduce a bill that passed the Senate with bipartisan support in the 107th Congress. This legislation addresses an equity issue for one of Alaska's rural village corporations.

Cape Fox Corporation is an Alaskan Village Corporation organized pursuant to the Alaska Native Claims Settlement Act, by the Native Village of Saxman, near Ketchikan, AK. As with other ANCSA village corporations in Southeast Alaska, Cape Fox was limited to selecting 23,040 acres under Section 16. However, unlike other village corporations, Cape Fox was further restricted from selecting lands within 6 miles of the boundary of the home rule city of Ketchikan. All other ANCSA corporations were restricted from selecting within 2 miles of such a home rule of city.

The 6-mile restriction went beyond protecting Ketchikan's watershed and damaged Cape Fox by preventing the corporation from selecting valuable timber lands, industrial sites, and other commercial property, not only in its core township, but in surrounding lands far removed from Ketchikan and its watershed. AS a result of the 6-mile restriction, only the mountainous northeast corner of Cape Fox's core township, which is nonproductive and of no economic value, was available for selection by the corporation. Cape Fox's land selections were further limited by the fact that the Annette Island Indian Reservation is within its selection area, and those lands were unavailable for ANCSA selection. Cape Fox is the only ANCSA village corporation affected by this restriction.

Clearly, Cape Fox was placed on unequal economic footing relative to other village corporations in Southeast Alaska. Despite its best efforts during the years since ANCSA was signed into law, Cape Fox has been unable to overcome the disadvantage the law built into its land selection opportunities by this inequitable treatment.

To address this inequity, I have introduced the Cape Fox Land Entitlement Adjustment Act of 2003. This bill will address the Cape Fox problem by providing three interrelated remedies:

(1) The obligation of Cape Fox to select and seek conveyance of the approximately 160 acres of unusable land in the mountainous northeast corner of Cape Fox's core township will be annulled.

(2) Cape Fox will be allowed to select and the Secretary of the Interior will be directed to convey 99 acres of timber land adjacent to Cape Fox's current holdings on Revilla Island.

(3) Cape Fox and the Secretary of Agriculture will be authorized to enter into an equal value exchange of lands in Southeast Alaska that will be of mutual benefit to the Corporation and the U.S. Forest Service. Lands conveyed to Cape Fox in this exchange will not be timberlands, but will be associated with a mining property containing existing Federal mining claims, some of which are patented. Lands anticipated to be returned to Forest Service ownership will be of wildlife habitat, recreation and watershed values and will consolidate Forest Service holdings in the George Inlet area of Revilla Island.

The land exchange provisions of this bill will help rectify the long-standing inequities associated with restrictions placed on Cape Fox in ANCSA. It will help allow this Native village corporation to make the transition from its major dependence on timber harvest to a more diversified portfolio of income-producing lands.

The bill also provides for the resolution of a long-standing land ownership problem with the Tongass National Forest. The predominant private landowner in the region, Sealaska Corporation, holds the subsurface estate on several thousand acres of National Forest System lands. This split estate poses a management problem which the Forest Service has long sought to resolve. Efforts to address this issue go back more than a decade. Provisions in the Cape Fox Land Entitlement Act of 2003 will allow the agency to consolidate its surface and subsurface estate and greatly enhance its management effectiveness and efficiency in the Tongass National Forest. I urge my colleagues to support this important legislation. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1354

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 1. SHORT TITLE.

This Act may be cited as the ''Cape Fox Land Entitlement Adjustment Act of 2003''.

SEC. 2. FINDINGS.

Congress finds that:

(1) Cape Fox Corporation (Cape Fox) is an Alaska Native Village Corporation organized pursuant to the Alaska Native Claims Settlement Act (ANCSA) (43 U.S.C. 1601 et seq.) for the Native Village of Saxman.

(2) As with other ANCSA village corporations in Southeast Alaska, Cape Fox was limited to selecting 23,040 acres under section 16 of ANCSA.

(3) Except for Cape Fox, all other Southeast Alaska ANCSA village corporations were restricted from selecting within two miles of a home rule city.

(4) To protect the watersheds in the vicinity of Ketchikan, Cape Fox was restricted from selecting lands within six miles from the boundary of the home rule City of Ketchikan under section 22(1) of ANCSA (43 U.S.C. 1621(1)).

(5) The six mile restriction damaged Cape Fox by precluding the corporation from selecting valuable timber lands, industrial sites, and other commercial property, not only in its core township but in surrounding lands far removed from Ketchikan and its watershed.

(6) As a result of the 6 mile restriction, only the remote mountainous northeast corner of Cape Fox's core township, which is nonproductive and of no known economic value, was available for selection by the corporation. Selection of this parcel was, however, mandated by section 16(b) of ANCSA (43 U.S.C. 1615(b)).

(7) Cape Fox's land selections were further limited by the fact that the Annette Island Indian Reservation is within its selection area, and those lands were unavailable for ANCSA selection. Cape Fox is the only ANCSA village corporation affected by this restriction.

(8) Adjustment of Cape Fox's selections and conveyances of land under ANCSA requires adjustment of Sealaska Corporation's (Sealaska) selections and conveyances to avoid creation of additional split estate between National Forest System surface lands and Sealaska subsurface lands.

(9) Sealaska is the Alaska native regional corporation for Southeast Alaska, organized under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

(10) There is an additional need to resolve existing areas of Sealaska/Tongass split estate, in which Sealaska holds title or conveyance rights to several thousand acres of subsurface lands that encumber management of Tongass National Forest surface lands.

(11) The Tongass National Forest lands identified in this Act for selection by and conveyance to Cape Fox and Sealaska, subject to valid existing rights, provide a means to resolve some of the Cape Fox and Sealaska ANCSA land entitlement issues without significantly affecting Tongass National Forest resources, uses or values.

(12) Adjustment of Cape Fox's selections and conveyances of land under ANCSA through the provisions of this Act, and the related adjustment of Sealaska's selections and conveyances hereunder, are in accordance with the purposes of ANCSA and otherwise in the public interest.

SEC. 3. WAIVER OF CORE TOWNSHIP REQUIREMENT FOR CERTAIN LANDS.

Notwithstanding the provisions of section 16(b) of ANCSA (43 U.S.C. 1615(b)), Cape Fox shall not be required to select or receive conveyance of approximately 160 acres of Federal unconveyed lands within Section 1, T. 75 S., R. 91 E., C.R.M.

SEC. 4. SELECTION OUTSIDE EXTERIOR SELECTION BOUNDARY.

(a) SELECTION AND CONVEYANCE OF SURFACE ESTATE.—In addition to lands made available for selection under ANCSA, within 24 months after the date of enactment of this Act, Cape Fox may select, and, upon receiving written notice of such selection, the Secretary of the Interior shall convey approximately 99 acres of the surface estate of Tongass National Forest lands outside Cape Fox's current exterior selection boundary, specifically that parcel described as follows:

(1) T. 73 S., R. 90 E., C.R.M.

(2) Section 33: SW portion of SE¼: 38 acres.

(3) Section 33: NW portion of SE¼: 13 acres.

(4) Section 33: SE¼ of SE¼: 40 acres.

(5) Section 33: SE¼ of SW¼: 8 acres.

(b) CONVEYANCE OF SUBSURFACE ESTATE.—Upon conveyance to Cape Fox of the surface estate to the lands identified in subsection (a), the Secretary of the Interior shall convey to Sealaska the subsurface estate to the lands.

(c) TIMING.—The Secretary of the Interior shall complete the interim conveyances to Cape Fox and Sealaska under this section within 180 days after the Secretary of the Interior receives notice of the Cape Fox selection under subsection (a).

SEC. 5. EXCHANGE OF LANDS BETWEEN CAPE FOX AND THE TONGASS NATIONAL FOREST.

(a) GENERAL.—The Secretary of Agriculture shall offer, and if accepted by Cape Fox, shall exchange the Federal lands described in subsection (b) for lands and interests therein identified by Cape Fox under subsection (c) and, to the extent necessary, lands and interests therein identified under subsection (d).

(b) LANDS TO BE EXCHANGED TO CAPE FOX.—The lands to be offered for exchange by the Secretary of Agriculture are Tongass National Forest lands comprising approximately 2,663.9 acres in T. 36 S., R. 62 E., C.R.M. and T. 35 S., R. 62 E., C.R.M., as designated upon a map entitled ''Proposed Kensington Project Land Exchange'', dated March 18, 2002, and available for inspection in the Forest Service Region 10 regional office in Juneau, Alaska.

(c) LANDS TO BE EXCHANGED TO THE UNITED STATES.—Cape Fox shall be entitled, within 60 days after the date of enactment of this Act, to identify in writing to the Secretaries of Agriculture and the Interior the lands and interests in lands that Cape Fox proposes to exchange for the Federal lands described in subsection (b). The lands and interests in lands shall be identified from lands previously conveyed to Cape Fox comprising approximately 2,900 acres and designated as parcels A–1 to A–3, B–1 to B–3, and C upon a map entitled ''Cape Fox Corporation ANCSA Land Exchange Proposal'', dated March 15, 2002, and available for inspection in the Forest Service Region 10 regional office in Juneau, Alaska. Lands identified for exchange within each parcel shall be contiguous to adjacent National Forest System lands and in reasonably compact tracts. The lands identified for exchange shall include a public trail easement designated as D on said map, unless the Secretary of Agriculture agrees otherwise. The value of the easement shall be included in determining the total value of lands exchanged to the United States.

(d) VALUATION OF EXCHANGE LANDS.—The Secretary of Agriculture shall determine whether the lands identified by Cape Fox under subsection (c) are equal in value to the lands described in subsection (b). If the lands identified under subsection (c) are determined to have insufficient value to equal the value of the lands described in subsection (b), Cape Fox and the Secretary shall mutually identify additional Cape Fox lands for exchange sufficient to equalize the value of lands conveyed to Cape Fox. Such land shall be contiguous to adjacent National Forest System lands and in reasonably compact tracts.

(e) CONDITIONS.—The offer and conveyance of Federal lands to Cape Fox in the exchange shall, notwithstanding section 14(f) of ANCSA, be of the surface and subsurface estate, but subject to valid existing rights and all other provisions of section 14(g) of ANCSA.

(f) TIMING.—The Secretary of Agriculture shall attempt, within 90 days after the date of enactment of this Act, to enter into an agreement with Cape Fox to consummate the exchange consistent with this Act. The lands identified in the exchange agreement shall be exchanged by conveyance at the earliest possible date after the exchange agreement is signed. Subject only to conveyance from Cape Fox to the United States of all its rights, title and interests in the Cape Fox lands included in the exchange consistent with this title, the Secretary of the Interior shall complete the interim conveyance to Cape Fox of the Federal lands included in the exchange within 180 days after the execution of the exchange agreement by Cape Fox and the Secretary of Agriculture.

SEC. 6. EXCHANGE OF LANDS BETWEEN SEALASKA AND THE TONGASS NATIONAL FOREST.

(a) GENERAL.—Upon conveyance of the Cape Fox lands included in the exchange under section 5 and conveyance and relinquishment by Sealaska in accordance with this title of the lands and interests in lands described in subsection (c), the Secretary of the Interior shall convey to Sealaska the Federal lands identified for exchange under subsection (b).

(b) LANDS TO BE EXCHANGED TO SEALASKA.—The lands to be exchanged to Sealaska are to be selected by Sealaska from Tongass National Forest lands comprising approximately 9,329 acres in T. 36 S., R. 62 E., C.R.M., T. 35 S., R. 62 E., C.R.M., and T. 34 S., Range 62 E., C.R.M., as designated upon a map entitled ''Proposed Sealaska Corporation Land Exchange Kensington Lands Selection Area'', dated April 2002 and available for inspection in the Forest Service Region 10 Regional Office in Juneau, Alaska. Within 60 days after receiving notice of the identification by Cape Fox of the exchange lands under section 5(c), Sealaska shall be entitled to identify in writing to the Secretaries of Agriculture and the Interior the lands that Sealaska selects to receive in exchange for the Sealaska lands described in subsection (c). Lands selected by Sealaska shall be in no more than two contiguous and reasonably compact tracts that adjoin the lands described for exchange to Cape Fox in section 5(b). The Secretary of Agriculture shall determine whether these selected lands are equal in value to the lands described in subsection (c) and may adjust the amount of selected lands in order to reach agreement with Sealaska regarding equal value. The exchange conveyance to Sealaska shall be of the surface and subsurface estate in the lands selected and agreed to by the Secretary but subject to valid existing rights and all other provisions of section 14(g) of ANCSA.

(c) LANDS TO BE EXCHANGED TO THE UNITED STATES.—The lands and interests therein to be exchanged by Sealaska are the subsurface estate underlying the Cape Fox exchange lands described in section 5(c), an additional approximately 2,506 acres of the subsurface estate underlying Tongass National Forest surface estate, described in Interim Conveyance No. 1673, and rights to be additional approximately 2,698 acres of subsurface estate of Tongass National Forest lands remaining to be conveyed to Sealaska from Group 1, 2 and 3 lands as set forth in the Sealaska Corporation/United States Forest Service Split Estate Exchange Agreement of November 26, 1991, at Schedule B, as modified on January 20, 1995.

(d) TIMING.—The Secretary of Agriculture shall attempt, within 90 days after receipt of the selection of lands by Sealaska under subsection (b), to enter into an agreement with Sealaska to consummate the exchange consistent with this Act. The lands identified in the exchange agreement shall be exchanged by conveyance at the earliest possible date after the exchange agreement is signed. Subject only to the Cape Fox and Sealaska conveyances and relinquishments described in subsection (a), the Secretary of the Interior shall complete the interim conveyance to Sealaska of the Federal lands selected for exchange within 180 days after execution of the

agreement by Sealaska and the Secretary of Agriculture.

(e) MODIFICATION OF AGREEMENT.—The executed exchange agreement under this section shall be considered a further modification of the Sealaska Corporation/United States Forest Service Split Estate Exchange Agreement, as ratified in section 17 of Public Law 102–415 (October 14, 1992).

SEC. 7. MISCELLANEOUS PROVISIONS.

(a) EQUAL VALUE REQUIREMENT.—The exchanges described in this Act shall be of equal value. Cape Fox and Sealaska shall have the opportunity to present to the Secretary of Agriculture estimates of value of exchange lands with supporting information.

(b) TITLE.—Cape Fox and Sealaska shall convey and provide evidence of title satisfactory to the Secretary of Agriculture for their respective lands to be exchanged to the United States under this Act, subject only to exceptions, reservations and encumbrances in the interim conveyance or patent from the United States or otherwise acceptable to the Secretary of Agriculture.

(c) HAZARDOUS SUBSTANCES.—Cape Fox, Sealaska, and the United States each shall not be subject to liability for the presence of any hazardous substance in land or interests in land solely as a result of any conveyance or transfer of the land or interests under this Act.

(d) EFFECT ON ANCSA SELECTIONS.—Any conveyance of Federal surface or subsurface lands to Cape Fox or Sealaska under this Act shall be considered, for all purposes, land conveyed pursuant to ANCSA. Nothing in this Act shall be construed to change the total acreage of land entitlement of Cape Fox or Sealaska under ANCSA. Cape Fox and Sealaska shall remain charged for any lands they exchange under this Act and any lands conveyed pursuant to section 4, but shall not be charged for any lands received under section 5 or section 6. The exchanges described in this Act shall be considered, for all purposes, actions which lead to the issuance of conveyances to Native Corporations pursuant to ANCSA. Lands or interests therein transferred to the United States under this Act shall become and be administered as part of the Tongass National Forest.

(e) EFFECT ON STATEHOOD SELECTIONS.—Lands conveyed to or selected by the State of Alaska under the Alaska Statehood Act (Public Law 85–508; 72 Stat. 339; 48 U.S.C. note prec. 21) shall not be eligible for selection or conveyance under this Act without the consent of the State of Alaska.

(f) MAPS.—The maps referred to in this Act shall be maintained on file in the Forest Service Region 10 Regional Office in Juneau, Alaska. The acreages cited in this Act are approximate, and if there is any discrepancy between cited acreage and the land depicted on the specified maps, the maps shall control. The maps do not constitute an attempt by the United States to convey State or private land.

(g) EASEMENTS.—Notwithstanding section 17(b) of ANCSA, Federal lands conveyed to Cape Fox or Sealaska pursuant to this Act shall be subject only to the reservation of public easements mutually agreed to and set forth in the exchange agreements executed under this Act. The easements shall include easements necessary for access across the lands conveyed under this Act for use of national forest or other public lands.

(h) OLD GROWTH RESERVES.—The Secretary of Agriculture shall add an equal number of acres to old growth reserves on the Tongass National Forest as are transferred out of Federal ownership as a result of this Act.

SEC. 8. AUTHORIZATION OF APPROPRIATIONS.

(a) DEPARTMENT OF AGRICULTURE.—There are authorized to be appropriated to the Secretary of Agriculture such sums as may be necessary for value estimation and related costs of exchanging lands specified in this Act, and for road rehabilitation, habitat and timber stand improvement, including thinning and pruning, on lands acquired by the United States under this Act.

(b) DEPARTMENT OF THE INTERIOR.—There are authorized to be appropriated to the Secretary of the Interior such sums as may be necessary for land surveys and conveyances pursuant to this Act.

By Mr. AKAKA (for himself, Mr. GRASSLEY Mr. LEVIN, Mr. LEAHY, and Mr. DURBIN):

S. 1358. A bill to amend chapter 23 of title 5, United States Code, to clarify the disclosure of information protected from prohibited personnel practices, require a statement in non-disclosure policies, forms, and agreements that such policies, forms, and agreements conform with certain disclosure protections, provide certain authority for the Special Council, and for other purposes; to the Committee on Governmental Affairs.

Mr. AKAKA. Mr. President, I rise today to discuss the Federal Employee Protection of Disclosures Act. I offered legislation under this title earlier this month. I am modifying that measure, S. 1229, by introducing a new bill today which is cosponsored by Senators GRASSLEY, LEVIN, LEAHY, and DURBIN. This bill, as with S. 1229, amends the Whistleblower Protection Act, WPA. These amendments are necessary to safeguard Federal employees from retaliation and protect American taxpayers from government waste, fraud, and abuse. Our bill follows S. 995 and S. 3070, the latter of which was favorably reported by the Governmental Affairs Committee in the 107th Congress. The bill we introduce today is the result of a bipartisan compromise to protect our federal whistleblowers.

Our bill would codify the repeated and unequivocal statements of congressional intent that Federal employees are to be protected when making ''any disclosure'' evidencing violations of law, gross mismanagement, or a gross waste of funds. The bill would also clarify the test that must be met to prove that a Federal employee reasonably believed that his or her disclosure was evidence of wrongdoing. The clear language of the WPA says that an employee is protected for disclosing information he or she reasonably believes evidences a violation. However, the Federal Circuit Court of Appeals, which has sole jurisdiction over whistleblower cases, ruled in 1999 that the reasonableness review must begin with the presumption that public officers perform their duties in good faith and that this presumption stands unless there is ''irrefragable proof'' to the contrary. As irrefragable means impossible to refute, our bill replaces this excessively high burden with the more reasonable standard of substantial evidence.

The measure would also provide independent litigating authority to the Office of Special Counsel, OSC. Under current law, OSC has no authority to request the Merit Systems Protection Board, MSPB, to reconsider its decision or to seek review of a MSPB decision by the Federal Circuit. The limitation undermines both OSC's ability to protect whistleblowers and the integrity of the WPA. As such, our bill would provide OSC authority to appear in any civil action brought in connection with the WPA and obtain review of any MSPB order where OSC determines MSPB erred and the case will impact the enforcement of the WPA.

Our bill would codify an ''anti-gag'' provision that Congress has passed annually since 1988 as part of the appropriations process. The yearly appropriations language bars agencies from implementing or enforcing any nondisclosure policy, form, or agreement that does not contain specified language preserving open government statutes. In addition, the bill would make it a prohibited personnel practice to enforce a non-disclosure agreement that does not comply with open government statutes.

Enactment of the Federal Employee Protection of Disclosures Act will strengthen the rights and protections afforded to federal whistleblowers and encourage the disclosure of information vital to an effective government. Following the events of September 11, we realized that whistleblowing is even more important when our national security is at stake. In many instances, the security of our Nation depends upon those who step forward to blow the whistle on significant lapses in our efforts to protect the United States against potential terrorist attacks. Congress should act quickly to assure whistleblowers that disclosing illegal activities and mismanagement within their agencies will not be met with retaliation. I urge my colleagues to join with me in protecting our federal whistleblowers.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1358

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PROTECTION OF CERTAIN DISCLOSURES OF INFORMATION BY FEDERAL EMPLOYEES.

(a) SHORT TITLE.—This Act may be cited as the ''Federal Employee Protection of Disclosures Act''.

(b) CLARIFICATION OF DISCLOSURES COVERED.—Section 2302(b)(8) of title 5, United States Code, is amended—

(1) in subparagraph (A)—

(A) by striking ''which the employee or applicant reasonably believes evidences'' and inserting '', without restriction to time, place, form, motive, context, or prior disclosure made to any person by an employee or applicant, including a disclosure made in the ordinary course of an employee's duties, that the employee or applicant reasonably believes is evidence of''; and

(B) in clause (i), by striking ''a violation'' and inserting ''any violation'';

(2) in subparagraph (B)—

(A) by striking ''which the employee or applicant reasonably believes evidences'' and inserting '', without restriction to time, place, form, motive, context, or prior disclosure made to any person by an employee or applicant, including a disclosure made in the ordinary course of an employee's duties, to the Special Counsel, or to the Inspector General of an agency or another employee designated by the head of the agency to receive such disclosures, of information that the employee or applicant reasonably believes is evidence of''; and

(B) in clause (i), by striking ''a violation'' and inserting ''any violation (other than a violation of this section)''; and

(3) by adding at the end the following:

''(C) a disclosure that—

''(i) is made by an employee or applicant of information required by law or Executive order to be kept secret in the interest of national defense or the conduct of foreign affairs that the employee or applicant reasonably believes is direct and specific evidence of—

''(I) any violation of any law, rule, or regulation;

''(II) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety; or

''(III) a false statement to Congress on an issue of material fact; and

''(ii) is made to—

''(I) a member of a committee of Congress having a primary responsibility for oversight of a department, agency, or element of the Federal Government to which the disclosed information relates and who is authorized to receive information of the type disclosed;

''(II) any other Member of Congress who is authorized to receive information of the type disclosed; or

''(III) an employee of Congress who has the appropriate security clearance and is authorized to receive information of the type disclosed.''.

(c) COVERED DISCLOSURES.—Section 2302(b) of title 5, United States Code, is amended—

(1) in the matter following paragraph (12), by striking ''This subsection'' and inserting the following:

''This subsection''; and

(2) by adding at the end the following:

''In this subsection, the term 'disclosure' means a formal or informal communication or transmission.''.

(d) REBUTTABLE PRESUMPTION.—Section 2302(b) of title 5, United States Code, is amended by adding after the matter following paragraph (12) (as amended by subsection (c) of this section) the following:

''For purposes of paragraph (8), any presumption relating to the performance of a duty by an employee who has authority to take, direct others to take, recommend, or approve any personnel action may be rebutted by substantial evidence.''.

(e) NONDISCLOSURE POLICIES, FORMS, AND AGREEMENTS; SECURITY CLEARANCES; AND RETALIATORY INVESTIGATIONS.—

(1) PERSONNEL ACTION.—Section 2302(a)(2)(A) of title 5, United States Code, is amended—

(A) in clause (x), by striking ''and'' after the semicolon; and

(B) by redesignating clause (xi) as clause (xiv) and inserting after clause (x) the following:

''(xi) the implementation or enforcement of any nondisclosure policy, form, or agreement;

''(xii) a suspension, revocation, or other determination relating to a security clearance;

''(xiii) an investigation of an employee or applicant for employment because of any activity protected under this section; and''.

(2) PROHIBITED PERSONNEL PRACTICE.—Section 2302(b) of title 5, United States Code, is amended—

(A) in paragraph (11), by striking ''or'' at the end;

(B) in paragraph (12), by striking the period and inserting a semicolon; and

(C) by inserting after paragraph (12) the following:

''(13) implement or enforce any nondisclosure policy, form, or agreement, if such policy, form, or agreement does not contain the following statement:

'' 'These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by Executive Order No. 12958; section 7211 of title 5, United States Code (governing disclosures to Congress); section 1034 of title 10, United States Code (governing disclosure to Congress by members of the military); section 2302(b)(8) of title 5, United States Code (governing disclosures of illegality, waste, fraud, abuse, or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential Government agents); and the statutes which protect against disclosures that could compromise national security, including sections 641, 793, 794, 798, and 952 of title 18, United States Code, and section 4(b) of the Subversive Activities Control Act of 1950 (50 U.S.C. 783(b)). The definitions, requirements, obligations, rights, sanctions, and liabilities created by such Executive order and such statutory provisions are incorporated into this agreement and are controlling.'; or

''(14) conduct, or cause to be conducted, an investigation of an employee or applicant for employment because of any activity protected under this section.''.

(3) BOARD AND COURT REVIEW OF ACTIONS RELATING TO SECURITY CLEARANCES.—

(A) IN GENERAL.—Chapter 77 of title 5, United States Code, is amended by inserting after section 7702 the following:

''§ 7702a. Actions relating to security clearances

''(a) In any appeal relating to the suspension, revocation, or other determination relating to a security clearance, the Merit Systems Protection Board or any reviewing court—

''(1) shall determine whether section 2302 was violated;

''(2) may not order the President to restore a security clearance; and

''(3) subject to paragraph (2), may issue declaratory relief and any other appropriate relief.

''(b)(1) If, in any final judgment, the Board or court declares that any suspension, revocation, or other determination with regards to a security clearance was made in violation of section 2302, the affected agency shall conduct a review of that suspension, revocation, or other determination, giving great weight to the Board or court judgment.

''(2) Not later than 30 days after any Board or court judgment declaring that a security clearance suspension, revocation, or other determination was made in violation of section 2302, the affected agency shall issue an unclassified report to the congressional committees of jurisdiction (with a classified annex if necessary), detailing the circumstances of the agency's security clearance suspension, revocation, or other determination. A report under this paragraph shall include any proposed agency action with regards to the security clearance.

''(c) An allegation that a security clearance was revoked or suspended in retaliation for a protected disclosure shall receive expedited review by the Office of Special Counsel, the Merit Systems Protection Board, and any reviewing court.''.

(B) TECHNICAL AND CONFORMING AMENDMENT.—The table of sections for chapter 77 of title 5, United States Code, is amended by inserting after the item relating to section 7702 the following:

''7702a. Actions relating to security clearances.''.

(f) EXCLUSION OF AGENCIES BY THE PRESIDENT.—Section 2302(a)(2)(C) of title 5, United States Code, is amended by striking clause (ii) and inserting the following:

''(ii)(I) the Federal Bureau of Investigation, the Central Intelligence Agency, the Defense Intelligence Agency, the National Imagery and Mapping Agency, the National Security Agency; and

''(II) as determined by the President, any Executive agency or unit thereof the principal function of which is the conduct of foreign intelligence or counterintelligence activities, if the determination (as that determination relates to a personnel action) is made before that personnel action; or''.

(g) ATTORNEY FEES.—Section 1204(m)(1) of title 5, United States Code, is amended by striking ''agency involved'' and inserting ''agency where the prevailing party is employed or has applied for employment''.

(h) DISCIPLINARY ACTION.—Section 1215 of title 5, United States Code, is amended in subsection (a), by striking paragraph (3) and inserting the following:

''(3)(A) A final order of the Board may impose—

''(i) disciplinary action consisting of removal, reduction in grade, debarment from Federal employment for a period not to exceed 5 years, suspension, or reprimand;

''(ii) an assessment of a civil penalty not to exceed $1,000; or

''(iii) any combination of disciplinary actions described under clause (i) and an assessment described under clause (ii).

''(B) In any case in which the Board finds that an employee has committed a prohibited personnel practice under section 2302(b)(8) or (9), the Board shall impose disciplinary action if the Board finds that the activity protected under section 2302(b)(8) or (9) was a significant motivating factor, even if other factors also motivated the decision, for the employee's decision to take, fail to take, or threaten to take or fail to take a personnel action, unless that employee demonstrates, by preponderance of evidence, that the employee would have taken, failed to take, or threatened to take or fail to take the same personnel action, in the absence of such protected activity.''.

(i) DISCLOSURES TO CONGRESS.—Section 2302 of title 5, United States Code, is amended by adding at the end the following:

''(f) Each agency shall establish a process that provides confidential advice to employees on making a lawful disclosure to Congress of information that is specifically required by law or Executive order to be kept secret in the interest of national defense or the conduct of foreign affairs.''.

(j) AUTHORITY OF SPECIAL COUNSEL RELATING TO CIVIL ACTIONS.—

(1) REPRESENTATION OF SPECIAL COUNSEL.—Section 1212 of title 5, United States Code, is amended by adding at the end the following:

''(h) Except as provided in section 518 of title 28, relating to litigation before the Supreme Court, attorneys designated by the Special Counsel may appear for the Special Counsel and represent the Special Counsel in any civil action brought in connection with section 2302(b)(8) or subchapter III of chapter 73, or as otherwise authorized by law.''.

(2) JUDICIAL REVIEW OF MERIT SYSTEMS PROTECTION BOARD DECISIONS.—Section 7703 of title 5, United States Code, is amended by adding at the end the following:

''(e)(1) Except as provided under paragraph (2), this paragraph shall apply to any review obtained by the Special Counsel. The Special Counsel may obtain review of any final order or decision of the Board by filing a petition for judicial review in the United States Court of Appeals for the Federal Circuit if the Special Counsel determines, in the discretion of the Special Counsel, that the Board erred in deciding a case arising under section 2302(b)(8) or subchapter III of chapter 73 and that the Board's decision will have a substantial impact on the enforcement of section 2302(b)(8) or subchapter III of chapter 73. If the Special Counsel was not a party or did not intervene in a matter before the Board, the Special Counsel may not petition for review of a Board decision under this section unless the Special Counsel first petitions the Board for reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceedings before the Court of Appeals. The granting of the petition for judicial review shall be at the discretion of the Court of Appeals.

''(2) During the 5-year period beginning on the effective date of the Federal Employee Protection of Disclosures Act, this paragraph shall apply to any review obtained by the Special Counsel. The Special Counsel may obtain review of any final order or decision of the Board by filing a petition for judicial review in the United States Court of Appeals for the Federal Circuit or any court of appeals of competent jurisdiction as provided under subsection (b)(2) if the Special Counsel determines, in the discretion of the Special Counsel, that the Board erred in deciding a case arising under section 2302(b)(8) or subchapter III of chapter 73 and that the Board's decision will have a substantial impact on the enforcement of section 2302(b)(8) or subchapter III of chapter 73. If the Special Counsel was not a party or did not intervene in a matter before the Board, the Special Counsel may not petition for review of a Board decision under this section unless the Special Counsel first petitions the Board for reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceedings before the court of appeals. The granting of the petition for judicial review shall be at the discretion of the court of appeals.''.

(k) JUDICIAL REVIEW.—

(1) IN GENERAL.—Section 7703(b) of title 5, United States Code, is amended by striking paragraph (1) and inserting the following:

''(b)(1)(A) Except as provided in subparagraph (B) and paragraph (2) of this subsection, a petition to review a final order or final decision of the Board shall be filed in the United States Court of Appeals for the Federal Circuit. Notwithstanding any other provision of law, any petition for review must be filed within 60 days after the date the petitioner received notice of the final order or decision of the Board.

''(B) During the 5-year period beginning on the effective date of the Federal Employee Protection of Disclosures Act, a petition to review a final order or final decision of the Board shall be filed in the United States Court of Appeals for the Federal Circuit or any court of appeals of competent jurisdiction as provided under subsection (b)(2). Notwithstanding any other provision of law, any petition for review must be filed within 60 days after the date the petitioner received notice of the final order or decision of the Board.''.

(2) REVIEW OBTAINED BY OFFICE OF PERSONNEL MANAGEMENT.—Section 7703 of title 5, United States Code, is amended by striking subsection (d) and inserting the following:

''(d)(1) Except as provided under paragraph (2), this paragraph shall apply to any review obtained by the Director of the Office of Personnel Management. The Director of the Office of Personnel Management may obtain review of any final order or decision of the Board by filing, within 60 days after the date the Director received notice of the final order or decision of the Board, a petition for judicial review in the United States Court of Appeals for the Federal Circuit if the Director determines, in his discretion, that the Board erred in interpreting a civil service law, rule, or regulation affecting personnel management and that the Board's decision will have a substantial impact on a civil service law, rule, regulation, or policy directive. If the Director did not intervene in a matter before the Board, the Director may not petition for review of a Board decision under this section unless the Director first petitions the Board for a reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceeding before the Court of Appeals. The granting of the petition for judicial review shall be at the discretion of the Court of Appeals.

''(2) During the 5-year period beginning on the effective date of the Federal Employee Protection of Disclosures Act, this paragraph shall apply to any review obtained by the Director of the Office of Personnel Management. The Director of the Office of Personnel Management may obtain review of any final order or decision of the Board by filing, within 60 days after the date the Director received notice of the final order or decision of the Board, a petition for judicial review in the United States Court of Appeals for the Federal Circuit or any court of appeals of competent jurisdiction as provided under subsection (b)(2) if the Director determines, in his discretion, that the Board erred in interpreting a civil service law, rule, or regulation affecting personnel management and that the Board's decision will have a substantial impact on a civil service law, rule, regulation, or policy directive. If the Director did not intervene in a matter before the Board, the Director may not petition for review of a Board decision under this section unless the Director first petitions the Board for a reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceeding before the court of appeals. The granting of the petition for judicial review shall be at the discretion of the Court of Appeals.''.

(l) NONDISCLOSURE POLICIES, FORMS, AND AGREEMENTS.—

(1) IN GENERAL.—

(A) REQUIREMENT.—Each agreement in Standard Forms 312 and 4414 of the Government and any other nondisclosure policy, form, or agreement of the Government shall contain the following statement: ''These restrictions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by Executive Order No. 12958; section 7211 of title 5, United States Code (governing disclosures to Congress); section 1034 of title 10, United States Code (governing disclosure to Congress by members of the military); section 2302(b)(8) of title 5, United States Code (governing disclosures of illegality, waste, fraud, abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential Government agents); and the statutes which protect against disclosure that may compromise the national security, including sections 641, 793, 794, 798, and 952 of title 18, United States Code, and section 4(b) of the Subversive Activities Act of 1950 (50 U.S.C. 783(b)). The definitions, requirements, obligations, rights, sanctions, and liabilities created by such Executive order and such statutory provisions are incorporated into this agreement and are controlling.''

(B) ENFORCEABILITY.—Any nondisclosure policy, form, or agreement described under subparagraph (A) that does not contain the statement required under subparagraph (A) may not be implemented or enforced to the extent such policy, form, or agreement is inconsistent with that statement.

(2) PERSONS OTHER THAN GOVERNMENT EMPLOYEES.—Notwithstanding paragraph (1), a nondisclosure policy, form, or agreement that is to be executed by a person connected with the conduct of an intelligence or intelligence-related activity, other than an employee or officer of the United States Government, may contain provisions appropriate to the particular activity for which such document is to be used. Such form or agreement shall, at a minimum, require that the person will not disclose any classified information received in the course of such activity unless specifically authorized to do so by the United States Government. Such nondisclosure forms shall also make it clear that such forms do not bar disclosures to Congress or to an authorized official of an executive agency or the Department of Justice that are essential to reporting a substantial violation of law.

(m) CLARIFICATION OF WHISTLEBLOWER RIGHTS FOR CRITICAL INFRASTRUCTURE INFORMATION.—Section 214(c) of the Homeland Security Act of 2002 (Public Law 107–296) is amended by adding at the end the following: ''For purposes of this section a permissible use of independently obtained information includes the disclosure of such information under section 2302(b)(8) of title 5, United States Code.''.

(n) EFFECTIVE DATE.—This Act shall take effect 30 days after the date of enactment of this Act.

Mr. LEVIN. Mr. President, I am pleased to join Senators AKAKA, GRASSLEY, LEAHY, and DURBIN today in introducing the Federal Employees Protection of Disclosures Act. Our bill strengthens the law protecting employees who blow the whistle on fraud, waste, and abuse in federal programs.

Whistleblowers play a crucial role in ensuring that Congress and the public are aware of serious cases of waste, fraud, and mismanagement in government. Whistleblowing is never more important than when our national security is at stake. Since the terrorist attacks of September 11, 2001, courageous individuals have stepped forward to blow the whistle on significant lapses in our efforts to protect the United States against potential future attacks. Most notably, FBI Agent Coleen Rowley alerted Congress to serious institutional problems at the FBI and their impact on the agency's ability to effectively investigate and prevent terrorism.

In another example, two Border Patrol agents from my State of Michigan, Mark Hall and Bob Lindemann, risked their careers when they blew the whistle on Border Patrol and INS policies that were compromising security on

the Northern Border. Their disclosure led to my holding a hearing at the Permanent Subcommittee on Investigations in November 2001, that exposed serious deficiencies in the way Border Patrol and INS were dealing with aliens who were arrested while trying to enter the country illegally. Since the hearing, some of the most troublesome policies have been changed, improving the security situation and validating the two agents' concerns. Despite the fact that their concerns proved to be dead on, shortly after they blew the whistle, disciplinary action was proposed against the two agents. Fortunately in this case, whistleblower protections worked. The Office of Special Counsel conducted an investigation and the decision to discipline the agents was reversed. However, that disciplinary an action was proposed in the first place is a troubling reminder of how important it is for us to both strengthen protections for whistleblowers and empower the Office of Special Counsel to discipline managers who seek to muzzle employees.

Agent Rowley, Mark Hall and Bob Lindermann are simply the latest in a long line of Federal employees who have taken great personal risks in blowing the whistle on government waste, fraud, and mismanagement. Congress has long recognized the obligation we have to protect a Federal employee when he or she discloses evidence of wrongdoing in a Federal program. If an employee reasonably believes that a fraud or mismanagement is occurring, and that employee has the courage and the sense of responsibility to make that fraud or mismanagement known, it is our duty to protect the employee from any reprisal. We want Federal employees to identify problems so we can fix them, and if they fear reprisal for doing so, then we are not only failing to protect the whistleblower, but we are also failing to protect the taxpayer.

I sponsored the Whistleblower Protection Act in 1989 which strengthened and clarified whistleblower rights, as well as the bill passed by Congress to strengthen the law further in 1994. Unfortunately, however, repeated holdings by the United States Court of Appeals for the Federal Circuit have corrupted the intent of Congress, with the result that additional clarifying language is sorely needed. The case of LaChance versus White represents perhaps the most notable example of the Federal Circuit's misinterpretation of the whistleblower law.

In LaChance, decided on May 14, 1999, the court imposed an unfounded and virtually unattainable standard on Federal employee whistleblowers in proving their cases. In that case, John E. White was an education specialist for the Air Force who spoke out against a new educational system that purported to mandate quality standards for schools contracting with the Air Force bases. White criticized the new system as counterproductive because it was too burdensome and seriously reduced the education opportunities available on base. After making these criticisms, local agency officials reassigned White, relieving him of his duties and allegedly isolating him. However, after an independent management review supported White's concerns, the Air Force canceled the program White had criticized. White appealed the reassignment in 1992 and the case has been in litigation ever since.

The administrative judge initially dismissed White's case, finding that his disclosures were not protected by the Whistleblower Protection Act. The MSPB, however, reversed the administrative judge's decision and remanded the case back to the administrative judge, holding that since White disclosed information he reasonably believed evidenced gross mismanagement, this disclosure was protected under the Act. On remand, the administrative judge found that the Air Force had violated the Whistleblower Protection Act and ordered the Air Force to return White to his prior status; the MSPB affirmed the decision of the administrative judge. OPM petitioned the Federal Circuit for a review of the board's decision. The Federal Circuit subsequently reversed the MSPB's decision, holding that there was not adequate evidence to support a violation under the Whistleblower Protection Act. The Federal Circuit held that the evidence that White was a specialist on the subject at issue and aware of the alleged improper activities and that his belief was shared by other employees was not sufficient to meet the ''reasonable belief'' test in the law. The court held that ''the board must look for evidence that it was reasonable to believe that the disclosures revealed misbehavior'' by the Air Force. The court went on to say: ''In this case, review of the Air Force's policy and implementation via the QES standards might well show them to be entirely appropriate, even if not the best option. Indeed, this review would start out with a presumption that public officers perform their duties correctly, fairly, in good faith, and in accordance with the law and governing regulations. * * * And this presumption stands unless there is 'irrefragable proof to the contrary'.''

It was appropriate for the Federal Circuit to remand the case to the MSPB to have it reconsider whether it was reasonable for White to believe that what the Air Force did in this case involved gross mismanagement. However, the Federal Circuit went on to impose a clearly erroneous and excessive standard for him to demonstrate his ''reasonable belief''—requiring him to provide ''irrefragable'' proof that the Air Force had engaged in gross mismanagement.

Irrefragable means ''undeniable, incontestable, incontrovertible, incapable of being overthrown.'' How can a Federal employee meet a standard of ''irrefragable'' in proving gross mismanagement? It is virtually impossible standard of proof to meet. Moreover, there is nothing in the law or legislative history that even suggests such a standard applies to the Whistleblower Protection Act. The intent of the law is not for a federal employee to act as an investigator and compile ''irrefragable'' proof that the Federal Government, in fact, committed fraud, waste or abuse. Rather, under the clear language of the statute, the employee needs only to have ''a reasonable belief'' that there is fraud, waste or abuse occurring in order to make a protected disclosure.

LaChance is only one example of the Federal Circuit misinterpreting the law. Our bill corrects LaChance and as well as several other Federal Circuit holdings. In addition, the bill strengthens the Office of Special Counsel and creates additional protections for federal employees who are retaliated against for blowing the whistle.

One of the most important issues addressed in the bill is to clarify again that the law is intended to protect a broad range of whistleblower disclosures. The legislative history supporting the 1994 Whistleblower Protection Act amendments emphasized: ''[I]t also is not possible to further clarify the clear language in section 2302(b)(8) that protection for 'any' whistleblowing disclosure truly means 'any'. A protected disclosure may be made as part of an employee's job duties, may concern policy or individual misconduct, and may be oral or written and to any audience inside or outside the agency, without restriction to time, place, motive or content.''

Despite this clear Congressional intent that was clearly articulated in 1994, the Federal Circuit has acted to push a number of whistleblower disclosures outside the protections of the whistleblower law. For example, in Horton versus the Department of the Navy, the Federal Circuit ruled that a whistleblower's disclosures to co-workers, or to the wrong-doer, or to a court ruled that a whistleblower's disclosures to official in the agency chain of command or those made in the course of normal job duties were not protected. In Huffman versus Office of Personnel Management, the Federal Circuit reaffirmed Horton and Willis. And in Meuwissen versus Department of Interior, the Federal Circuit held that a whistleblower's disclosures of previously known information do not qualify as ''disclosures'' under the WPA. All of these rulings violate clear Congressional intent to afford broad protection to whistleblower disclosures.

In order to make it clear that any lawful disclosure that an employee or job applicant reasonably believes is evidence of waste, fraud, abuse, or gross mismanagement is covered by the WPA, the bill codifies previous statements of Congressional intent. Using the 1994 legislative history, it amends the whistleblower statute to

cover any disclosure of information without restriction to time, place, form, motive or context, or prior disclosure made to any person by an employee or applicant, including a disclosure made in the ordinary course of an employee's duties that the employee or applicant reasonably believes is credible evidence of any violation of any law, rule, or regulation, or other misconduct specified in the whistleblower law. I want to emphasize here that, other than the explicitly listed exceptions identified in the statute, we intend for there to be no exceptions, inferred or otherwise, as to what is a protected disclosure. And the prohibition on inferred exceptions is intended to apply to all protected speech categories in section 2302(b)(8) of the law. The intent here, again, is to make it clear that when the WPA speaks of protecting disclosures by Federal employees ''any'' means ''any.''

The bill also addresses the clearly erroneous standard established by the Federal Circuit's LaChance decision I mentioned earlier. Rather than needing ''irrefragable proof'' to overcome the presumption that a public officer performed his or her duties correctly, fairly, in good faith, and in accordance with the law and regulations, the bill makes it clear that the whistleblower can rebut this presumption with ''substantial evidence.'' This burden of proof is a far more reasonable and appropriate standard for whistleblowing cases.

The Federal Circuit's repeated misinterpretations of the whistleblower law are unacceptable and demand Congressional action. In response to the court's inexplicable and inappropriate rulings, our bill would suspend for five years the Federal Circuit's exclusive jurisdiction over whistleblower appeals. It would instead allow a whistleblower to file a petition to review a final order or final decision of the MSPB in the Federal Circuit or in any other United States appellate court of competent jurisdiction and defined under 5 U.S.C. 7703(b)(2). In most cases, using another court would mean going to the federal circuit where the contested personnel action took place. This five year period would allow Congress to evaluate whether other appellate courts would issue whistleblower decisions which are consistent with the Federal Circuit's interpretation of WPA protections and guide Congressional efforts to clarify the law if necessary.

In addition to addressing jurisdictional issues and troublesome Federal Circuit precedents, our bill would also make important additions to the list of protected disclosures. First, it would subject certain disclosures of classified information to whistleblower protections. However, in order for a disclosure of classified information to be protected, the employee would have to possess a reasonable belief that the disclosure was direct and specific evidence of a violation of law, rule or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, a substantial and specified danger to public health or safety, or a false statement to Congress on an issue of material fact. A whistleblower must also limit the disclosure to a member of Congress or staff of the executive or legislative branch holding the appropriate security clearance and authorized to receive the information disclosed. Federal agencies covered by the WPA would be required to establish a process to provide confidential advice to employees on how to lawfully make a protected disclosure of classified information to Congress.

Current law permits Federal employees to file a case at the MSPB when they feel that a manager has taken a personnel action against them in retaliation for blowing the whistle. The legislation would add three new personnel actions to the list of adverse actions that cannot be taken against whistleblowers for engaging in protected activity. These actions would include enforcement of any nondisclosure policy, form or agreement against a whistleblower for making a protected disclosure; the suspension, revocation, or other determination relating to a whistleblower's security clearance; and an investigation of an employee or applicant for employment if taken due to their participation in whistleblowing activity.

It is important to note that, if it is demonstrated that a security clearance was suspended or revoked in retaliation for whistleblowing, the legislation limits the relief that the MSPB and reviewing court can order. The bill specifies that the MSPB or reviewing court may issue declaratory and other appropriate relief but may not direct a security clearance to be restored. Appropriate relief may include back pay, an order to reassign the employee, attorney fees, or any other relief the Board or court is authorized to provide for other prohibited personnel practices. In addition, if the Board finds an action on a security clearance to have been illegal, it may bar the agency from directly or indirectly taking any other personnel action based on that illegal security clearance action. Our legislation would also require the agency to review and provide a report to Congress detailing the circumstances of the agency's security clearance decision, and authorizes expedited MSPB review of whistleblower cases where a security clearance was revoked or suspended. The latter is important because a person whose clearance has been suspended or revoked and whose job responsibilities require clearance may be unable to work while their case is being considered.

Our bill would also add two prohibited personnel practices of the whistleblower law. First, it would codify the ''anti-gag'' provision that has been in force since 1988, by virture of its inclusion in appropriations bills. Second, it would prohibit a manager from initiating an investigation of an employee or applicant for employment because they engage in a protected activity, including whistleblowing.

Another issue addressed in the bill involves certain employees who are excluded from the WPA. Among these are employees who hold ''confidential policy-making positions.'' In 1994, Congress amended the WPA to keep agencies from designating employees confidential policymakers after the employees filed whistleblower complaints. The WPA also allows the President to exclude from WPA jurisdiction any agency whose principal function is the conduct of foreign intelligence or counterintelligence activities. Our legislation maintains this authority but makes it clear that a decision to exclude an agency from WPA protections must also be made prior to a personnel action being taken against a whistleblower from that agency. This provision is necessary to ensure that agencies cannot argue that employees are exempt from whistleblower protections after an employee files a claim that they were retaliated against.

Another key section of the bill would strengthen the Office of Special Counsel. OSC is the independent federal agency responsible for investigating and prosecuting federal employee complaints of whistleblower retaliation. Current law, however, limits OSC's ability to effectively enforce and defend whistleblower laws. For example, the law provides the OSC with no authority to request the Merit Systems Protection Board to reconsider one of its decisions or to seek appellate review of an MSPB decision. Even when another party petitions for a review of a MSPB decision, OSC is typically denied the right to participate in the proceedings.

Our bill would provide explicit authority for the Office of Special Counsel to appear in any civil action brought in connection with the whistleblower law. In addition, it would authorize OSC to obtain circuit court review of any MSPB order in a whistleblowing case if the OSC determines the Board erred and the case would have a substantial impact on the enforcement of the whisltleblower statute. In a letter to me addressing these provisions, special Counsel Elaine Kaplan said, ''I believe that these changes are necessary, not only to ensure OSC's effectiveness, but to address continuing concerns about the whittling away of the WPA's protections by narrow judicial interpretations of the law.'' I ask unanimous consent that the OSC letter be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

U.S. OFFICE OF SPECIAL COUNSEL,
Washington, DC, September 11, 2002.

Hon. CARL LEVIN,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR LEVIN: Thank you for giving me the opportunity to comment on the proposed Title VI of H.R. 5005, concerning

the protection of federal employee whistleblowers.

As the head of the U.S. Office of Special Counsel (OSC), the independent federal agency that is responsible for investigating and prosecuting federal employees' complaints of whistleblower retaliation, I share your recognition that is crucial to ensure that the laws protecting whistleblowers are strong and effective. Federal employees are often in the best position to observe and identify official misconduct or malfeasance as well as dangers to the public health and safety, and the national security.

Now, perhaps more than ever before, our national interest demands that federal workers feel safe to come forward to bring appropriate attention to these conditions so that they may be corrected. Further, and again more than ever, the public now needs assurance that the workforce which is carrying out crucial operations is alert, and that its leaders welcome and encourage their constructive participation in making the government a highly efficient and effective steward of the public interest.

To these ends, Title VI contains a number of provisions that will strengthen the Whistleblower Protection Act (WPA) and close loopholes in the Act's coverage. The amendment would reverse the effects of several judicial decisions that have imposed unduly narrow and restrictive tests for determining whether employees qualify for the protection of the WPA. These decisions, among other things, have held that employees are not protected against retaliation when they make their disclosures in the line of duty or when they confront subject officials with their suspicions of wrongdoing. They have also made it more difficult for whistleblowers to secure the Act's protection by interposing what the Court of Appeals for the Federal Circuit has called an ''irrefragable'' presumption that government officials perform their duties lawfully and in good faith.

In addition to reversing these rulings, Title VI would grant the Special Counsel independent litigating authority and the right to request judicial review of decisions of the Merit Systems Protection Board (MSPB) in cases that will have a substantial impact upon the enforcement of the WPA. I firmly believe that these changes are necessary, not only to ensure OSC's effectiveness, but to address continuing concerns about the whittling away of the WPA's protections by narrow judicial interpretations of the law. The changes would ensure that OSC, the government agency charged with protecting whistleblowers, will have a meaningful opportunity to participate in the shaping of the law.

Further, Title VI would strengthen OSC's capacity to use its disciplinary action authority to deter agency supervisors, managers, and other officials from engaging in retaliation, and to punish those who do so. The amendment does this in two ways. First, it clarifies the burden of proof in disciplinary action cases that OSC brings by employing the test first set forth by the Supreme Court in Mt. Healthy School District v. Board of Education. Under this test, in order to secure discipline of an agency official accused of engaging in whistleblower retaliation, OSC would have to show that protected whistleblowing was a ''significant, motivating factor'' in the decision to take or threaten to take a personnel action. If OSC made such a showing, the MSPB would order appropriate discipline unless the official showed, by preponderant evidence, that he or she would have taken or threatened to take the same action even had there been no protected activity.

This change is necessary in order to ensure that the burden of proof in these cases is not so onerous as to make it virtually impossible to secure discipline against retaliators. Under current law, OSC bears the unprecedented burden of demonstrating that protected activity was the but-for cause of an adverse personnel action against a whistleblower. The amendment would correct the imbalance by imposing the well-established Mt. Healthy test in these cases.

In addition, the bill would relieve OSC of attorney fee liability in disciplinary action cases in which it ultimately does not prevail. The amendment would shift liability for fees to the manager's employing agency, where an award of fees would be in the interest of justice. The employing agency would indemnify the manager for these costs which would have been incurred by him in the course of performing his official duties.

Under current law, if OSC ultimately does not prevail in a case it brings against a manager whom our investigation shows has engaged in retaliation, then we must pay attorney fees, even if our prosecution decision was an entirely reasonable one. For a small agency like OSC, with a limited budget, the specter of having to pay large attorney fee awards simply because we do not ultimately prevail in a case, is a significant obstacle to our ability to use this important authority to hold managers accountable. It is, moreover, an unprecedented burden; virtually all fee shifting provisions which could result in an award of fees against a government agency, depend upon a showing that the government agency has acted unreasonably or in bad faith.

In addition to these provisions, the bill would also provide that for a period of five years, beginning on February 1, 2003, there would be multi-circuit review of decisions of the MSPB, just as there is now multi-circuit review of decisions of the MSPB's sister agency, the Federal Labor Relations Authority. This experiment will give Congress the opportunity to judge whether providing broader perspectives of all of the nation's courts of appeals will enhance the development of the law under the WPA.

There are several other provisions of the amendments that would strengthen the Act's coverage and remedies. The amendments, for example, would extend coverage of the WPA to circumstances in which an agency initiated an investigation of an employee or applicant in reprisal for whistleblowing or where an agency implemented an illegal nondisclosure form or policy. The amendments also would authorize an award of compensatory damages in federal employee whistleblower cases. Such awards are authorized for federal employees under the civil rights acts, and for environmental and nuclear whistleblowers, among others, under other federal statutes. Given the important public policies underlying the WPA, it seems appropriate that the same sort of make whole relief should be available to federal employee whistleblowers.

Finally, Title VI contains a provision that would provide relief to employees who allege that their security clearances were denied or revoked because of protected whistleblowing, without interfering with the longstanding authority of the President to make security clearance determinations. The amendment would allow employees to file OSC complaints alleging they suffered a retaliatory adverse security clearance determination. OSC would be given the authority to investigate such complaints and the MSPB would have the authority to issue declaratory and appropriate relief other than ordering the restoration of the clearance. Further, where the Board found retaliation, the employing agency would be required to conduct its own investigation of the revocation and report back to Congress.

This amendment provides a balance resolution of the tension between protecting national security whistleblowers against retaliation and maintaining the President's traditional prerogative to decide who will have access to classified information. Especially in light of the current heightened concerns about issues of national security, this change in the law is clearly warranted.

Thank you again for providing me with an opportunity to comment on these amendments, and for your continuing interest in the work of the Office of Special Counsel.

Sincerely,

ELAINE KAPLAN.

Mr. LEVIN. OSC currently has the authority to pursue disciplinary action against managers who retaliate against whistleblowers. However, Federal Circuit decisions, like LaChance, have undermined the agency's ability to successfully pursue such cases. The Special Counsel has said that ''change is necessary in order to ensure that the burden of proof in these cases is not so onerous as to make it virtually impossible to secure disciplinary action against retaliators.'' In addition to it being difficult to win, if the OSC loses a disciplinary case, it has to pay the legal fees of those against whom OSC initiates disciplinary action. In its letter, OSC said that ''the specter of having to pay large attorney fee awards . . . is a significant obstacle to our ability to use this important authority to hold managers accountable.'' Our bill addresses these problems by establishing a reasonable burden of proof for disciplinary actions and requiring the employing agency, not the OSC, to reimburse the prevailing party for attorney fees in a disciplinary proceeding.

Finally, the bill addresses a new issue that has arisen in connection with the recent enactment of the Homeland Security Act or HSA. To evaluate the vulnerability to terrorist attack of certain critical infrastructure such as chemical plants, computer networks and other key facilities, the HSA asks private companies that own these facilities to submit unclassified information about them to the government. In doing so, the law also created some ambiguity on the question of whether Federal employee whistleblowers would be protected by the WPA if they should disclose information that has been independently obtained by the whistleblower about such facilities but which may also have been disclosed to the government under the critical infrastructure information program.

While I believe it was Congress's intent to extend whistleblower protections to Federal employees who disclose such independently obtained information, the law's ambiguities are troublesome in the context of the tendency of the Federal Circuit to narrowly construe the scope of protections afforded by the WPA. Our bill would thus clarify that whistleblower protections do extend to Federal employees who disclose independently obtained information that may also have been disclosed to the government as part of the

critical infrastructure information program

We need to encourage Federal employees to blow the whistle on waste, fraud and abuse in Federal Government agencies and programs. These people take great risks and often face enormous obstacles in doing what they believe is right. The Congress and the country owe a particular debt of gratitude to those whistleblowers who put their careers on the line to protect national security. Since September 11, 2001, we have seen a number of examples of how crucial people like Coleen Rowley, Mark Hall and Bob Lindermann are to keeping our country safe. I request unanimous consent that a letter from Agent Rowley be printed in the RECORD. In the letter she says that when she blew the whistle, she was lucky enough to garner the support of many of her colleagues and members of Congress. However, her letter warns that for every Coleen Rowley, ''there are many more who do not benefit from the relative safety of public notoriety.'' It is to protect those responsible, courageous many that we offer this legislation. We need more like them.

I ask unanimous consent to print in the RECORD a section-by-section explanation of the bill.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

SEPTEMBER 2, 2002.

DEAR SENATORS: I have proudly served in federal law enforcement for over 21 years. Prior to my personal involvement in a specific matter, I did not fully appreciate the strong disincentives that sometimes keep government employees from exposing waste, fraud, abuse, or other failures they witness on the job. Nor did I appreciate the strong incentives that do exist for agencies to avoid institutional embarrassment.

The decision to step forward with information that exposed my agency to scrutiny was one of the most difficult of my career. I did not come to it quickly or lightly. I first attempted to warn my superiors through regular channels. Only after those warnings failed to bring about the necessary response and congressional inquiry was initiated, did I go outside the agency with my concerns. I had no intention or desire to be in the public spotlight, so I did not go to the news media. I provided the information to Members of Congress with oversight responsibility. I felt compelled to do so because my responsibility is to the American people, not to a government agency.

Unfortunately, the cloak of secrecy which is necessary for the effective operation of government agencies involved in national security and criminal investigations fosters an environment where the incentives to avoid embarrassment and the disincentives to step forward combine. When that happens, the public loses. We need laws that strike a better balance, that are able to protect effective government operation without sacrificing accountability to the public. I was lucky enough to garner a good deal of support from my colleagues in the Minneapolis office and Members of Congress. But for every one like me, there are many more who do not benefit from the relative safety of public notoriety. They need credible, functioning rights and remedies to retain the freedom to warn.

I also need to state that I write this letter in my personal capacity, and that it reflects my personal views only, not those of the government agency for which I work.

Thank you for your consideration,

COLEEN ROWLEY.

There being no objection, the analysis was ordered to be printed in the RECORD, as follows:

SECTION-BY-SECTION ANALYSIS OF THE FEDERAL EMPLOYEE PROTECTION OF DISCLOSURES ACT

The Federal Employee Protection of Disclosures Act would strengthen protections for Federal employees who blow the whistle on waste, fraud and abuse in the Federal Government.

Protected Whistleblower Disclosures—To correct court decisions improperly limiting the disclosures protected by the Whistleblower Protection Act, WPA, section (b) of the bill would clarify Congressional intent that the law covers ''any'' whistleblowing disclosure, whether that disclosure is made as part of an employee's job duties, concerns policy or individual misconduct, is oral or written, or is made to any audience inside or outside an agency, and without restriction to time, place, motive or context. This section would also protect certain disclosures of classified information to Congress when the disclosure is to a Member or legislative staff holding an appropriate security clearance and authorized to receive the type of information disclosed.

Informal Disclosures.—Section (c) would clarify the definition of ''disclosure'' to include a formal or informal communication or transmission.

Irrefragable Proof.—In *LaChance v. White*, the U.S. Court of Appeals for the Federal Circuit imposed an erroneous standard for determining when an employee makes a protected disclosure under the WPA. Under the clear language of the statute, an employee need only have a reasonable belief that he or she is providing evidence of fraud, waste or abuse to make a protected disclosure. But the court ruled that an employee had to have ''irrefragable proof''—meaning undeniable and incontestable proof—to overcome the presumption that a public officer is performing their duties in accordance with law. Section (d) would replace this unreasonable standard of proof by providing that a whistleblower can rebut the presumption with ''substantial evidence.''

Prohibited Personnel Actions.—Section (e)(1) would add three actions to the list of prohibited personnel actions that may not be taken against whistleblowers for protected disclosures: enforcement of a nondisclosure policy, form or agreement; suspension, revocation, or other determination relating to an employee's security clearance; and investigation of an employee or applicant for employment due to protected whistleblowing activities.

Nondisclosure Actions Against Whistleblowers.—Section (e)(2) would bar agencies from implementing or enforcing against whistleblowers any nondisclosure policy, form or agreement that fails to contain specified language preserving the right of federal employees to disclose certain protected information. It would also prohibit a manager from initiating an investigation of an employee or applicant for employment because they engaged in protected activity.

Retaliations Involving Security Clearances.—Section (e)(3) would make it a prohibited personnel practice for a manager to suspend, revoke or take other action with respect to an employee's security clearance in retaliation for whistleblowing. This section would also authorize the Merit Systems Protection Board, MSPB, to conduct an expedited review of such matters and issue declaratory and other appropriate relief, but would not empower MSPB to restore a security clearance. If MSPB or a reviewing court were to find that a security clearance decision was retaliatory, the agency involved would be required to review its security clearance decision and issue a report to Congress explaining it.

Exclusions From WPA.—Current law allows the President to exclude certain employees and agencies from the WPA if they perform certain intelligence related or policy making functions. In 1994, Congress amended the WPA to stop agencies from removing employees from WPA coverage after the employees filed whistleblower complaints. Section (f) would also require that removal of an agency from the WPA be made prior to a personnel action being taken against a whistleblower at that agency.

Attorney Fees.—The Office of Special Counsel, OSC, has authority to pursue disciplinary action against managers who retaliate against whistleblowers. Currently, if OSC loses a disciplinary case, it must pay the legal fees of those against whom it initiated the action. Because the amounts involved could significantly deplete OSC's limited resources, section (g) would require the employing agency, rather than OSC, to reimburse the manager's attorney fees.

Burden of Proof in Disciplinary Actions.—Currently, when OSC pursues disciplinary action against managers who retaliate against whistleblowers, OSC must demonstrate that an adverse personnel action would not have occurred ''but for'' the whistleblower's protected activity. Section (i) would establish a more reasonable burden of proof by requiring OSC to demonstrate that the whistleblower's protected disclosure was a ''significant motivating factor'' in the decision by the manager to take the adverse action, even if other factors also motivated the decision. This standard would be equivalent of the Mt. Healthy standard.

Disclosures to Congress.—Section (j) would require agencies to establish a process to provide confidential advice to employees on how to lawfully make a protected disclosure of classified information to Congress.

Authority of Special Counsel.—Under current law, OSC has no authority to request MSPB to reconsider a decision or seek appellate review of a MSPB decision. This limitation undermines OSC's ability to protect whistleblowers and integrity of the WPA. Section k would authorize OSC to appear in any civil action brought in connection with the WPA and request appellate review of any MSPB order where OSC determines MSPB erred and the case would have a substantial impact on WPA enforcement.

Judicial Review.—In 1982, Congress replaced normal Administrative Procedures Act appellate review of MSPB decisions with exclusive jurisdiction in the U.S. Court of Appeals for the Federal Circuit. While the 1989 WPA and its 1994 amendments strengthened and clarified whistleblower protections, Federal Circuit holdings have repeatedly misinterpreted key provisions of the law. Subject to a five year sunset , section (l) would suspend the Federal Circuit's exclusive jurisdiction over whistleblower appeals and allow petitions for review to be filed either in the Federal Circuit or any other federal circuit court of competent jurisdiction.

Nondisclosure Restrictions on Whistleblowers.—Section (m) would require all federal nondisclosure policies, forms and agreements to contain specified language preserving the right of federal employees to disclose certain protected information. This section would codify the so-called anti-gag provision that has been included in federal appropriations bills since 1988.

Critical Infrastructure Information.—Section (n) would clarify that section 214(c) of

the Homeland Security Act, HSA, maintains existing WPA rights for independently obtained information that may also qualify as critical infrastructure information under the HSA.

By Mrs. BOXER:

S. 1359. A bill to allow credit unions to provide international money transfer services and to require disclosures in connection with international money transfers from all money transmitting service providers; to the Committee on Banking, Housing, and Urban Affairs.

Mrs. BOXER. Mr. President, today, I am introducing the International Remittances Services Enhancement and Protection Act of 2003.

Remittances are the funds that immigrants send to their families abroad to help those relatives meet their basic needs. In the Latino community, 47 percent of all Latinos born outside the United States regularly send money to their country of origin. But since 43 percent to 58 percent of those who send remittances abroad regularly do not have a bank account, much of their hard earned money is lost in fees paid to check cashing agencies and wire transfer companies. They rely on check cashing services to cash their paychecks at hefty fees and then pay another fee to send some portion of that money through a wire service to their relatives in Latin America and elsewhere at varying exchange rates.

This legislation will increase competition and transparency in the remittances market. It will provide immigrants with access to more choices for sending remittances by allowing credit unions to provide wire transfer and check cashing services to nonmembers. It will also provide immigrants with access to information in more than one language from all money transmitters about the fees and exchange rates that they pay. That information will make it easier for consumers to compare the value of the services they can receive from different service providers.

The larger goal is to provide immigrants with more control over their finances. I believe this bill with encourage financial institutions to develop better services for immigrants and build stronger relationships with immigrant communities.

According to the Multilateral Investment Fund, immigrants living in the United States sent $23 billion to Latin America in 2001. More than $3 billion of that total was consumed in fees paid to money transfer agencies. If current growth rates in remittance transfers are maintained, cumulative remittances to Latin America could reach $300 billion for the 10-year period ending in 2010. We need to work to ensure that competition in the market and modern technology come together to lower the portion of those monies lost in fees and instead are used for productive purposes.

By Mr. GRAHAM of Florida:

S. 1360. A bill to amend section 7105 of title 38, United States Code, to clarify the requirements for notices of disagreement for appellate review of Department of Veterans Affairs activities; to the Committee on Veterans' Affairs.

Mr. GRAHAM of Florida. Mr. President, I rise today to introduce legislation that will remove a significant and arbitrary barrier to appellate review of veterans' benefits claims. In 1988, when Congress created judicial review for veterans' claims it intended to provide ''an opportunity for those aggrieved by VA decisions to have such decisions reviewed by a court'' and found such review ''necessary in order to provide such claimants with fundamental justice.''

A veteran or survivor of a veteran seeking VA benefits must file a claim for such benefits, generally at a VA Regional Office. If the VA denies the claim for benefits, the claimant must file a ''Notice of Disagreement,'' or NOD, as defined in section 7105 of title 38 of the United States Code. This NOD initiates appellate review by the agency and begins a series of events where VA communicates the basis of the denial to the claimant and allows various levels of review of this denial at the regional office. If the claimant still disagrees with the VA decision, the claimant may file a ''Substantive Appeal'' that vests jurisdiction of the claim with the Board of Veterans' Appeals, the appellate arm of VA.

Section 7105 defines what is required of a valid NOD. It must be filed within 1 year from the notice of the initial denial, in writing, and filed with the regional office that issued the decision over which there is disagreement. The NOD may be filed by the claimant or the claimant's guardian or representative.

VA has promulgated regulations to implement section 7105. In Section 20.201 or title 38 of the Code of Federal Regulations, the Secretary defined a NOD to not require special wording. The regulation does require that the NOD ''must be in terms which can be reasonably construed as disagreement with the determination and a desire for appellate review.'' The second component of that sentence—''a desire for appellate review''—is not required under the statute.

In 1997, Raymond Gallegos, a veteran, again filed an application for service connection for post-traumatic stress disorder that had been previously denied. The VA regional office granted his claim. However, Mr. Gallegos believed the effective date assigned to his claim was wrong and filed what was then thought to be a NOD. He appealed this issue to the Board, which reasoned that the letter expressing his disagreement was not a valid NOD because it did not express his desire for appellate review. Mr. Gallegos appealed the Board's determination to the United States Court of Appeals for Veterans Claims, or the CAVC.

In 2000, the CAVC determined in Gallegos v. Gober that the VA regulation was invalid because it required more of the claimant than Congress required in statute. Last year, in Gallegos v. Principi, the United States Court of Appeals for the Federal Circuit reversed the CAVC and upheld the VA regulation, finding that the agency interpretation was entitled to deference because Congressional intent was not clear in limiting the requirements of a NOD to those in section 7105.

Congress never intended to require that level of formality from veterans, in this uniquely pro-claimant system. Therefore, I offer legislation that would specify that if a claimant's filing meets the criteria defined in section 7105 of title 38 of the United States Code, the document will be deemed a Notice of Disagreements with all the rights and procedures that accompany that determination. It will also ensure that claimants whose NODs were found to be defective since the court decision will have the opportunity to have their NOD reevaluated under this new provision.

This is very significant because there are two key consequences of not having a valid, timely NOD. First, if a claimant fails to file a timely, valid NOD, the VA denial becomes final. The claimant will need to submit ''new and material evidence'' that VA erred in order to reopen the case. If successful, the claimant will only be able to receive benefits dating to the beginning of the newly reopened claim, potentially losing years of retroactive benefits. This may affect a veteran's ability to receive VA health care, a dependent's ability to use educational benefits, and all the other benefits that flow from a finding of service-connection.

Second, if a claimant has not been deemed to file a NOD, there can be no appeal of the VA decision. A NOD is required to initiate an appeal. It is a prerequisite to review by the Board of Veterans' Appeals and ultimately judicial review at the CAVC. This contravenes Congress's intent to remove arbitrary barriers to judicial review as it did in Public Law 107–103.

We face the tragic fact that in 2002, America lost 646,264 veterans. The many aging veterans who still await justice cannot afford this debate. I ask my colleagues to support this critical measure and restore this fundamental justice to our veterans.

I ask unanimous consent that the text of this bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1360

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CLARIFICATION OF NOTICE OF DISAGREEMENT FOR APPELLATE REVIEW OF DEPARTMENT OF VETERANS AFFAIRS ACTIVITIES.

(a) CLARIFICATION.—Section 7105(b) of title 38, United States Code, is amended by adding at the end the following new paragraph:

''(3) A document that meets the requirements of the second sentence of paragraph (1) and the first sentence of paragraph (2) shall be recognized as a notice of disagreement for purposes of this section.''.

(b) EFFECTIVE DATE.—(1) Except as specifically provided otherwise, paragraph (3) of section 7105(b) of title 38, United States Code (as added by subsection (a) of this section), shall apply to any document—

(A) filed under section 7105 of such title on or after the date of the enactment of this Act; or

(B) filed under section 7105 of such title before the date of the enactment of this Act and not rejected by the Secretary of Veterans Affairs as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations, as of that date.

(2) In the case of a document described in paragraph (3) of this subsection, the Secretary shall, upon the request of the claimant or the Secretary's own motion, order the document treated as a notice of disagreement under section 7105 of such title as if the document had not been rejected by the Secretary as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations.

(3) A document described in this paragraph is a document that—

(A) was filed as a notice of disagreement under section 7105 of such title during the period beginning on March 15, 2002, and ending on the date of the enactment of this Act; and

(B) was rejected by the Secretary as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations.

(4) A document may not be treated as a notice of disagreement under paragraph (2) unless a request for such treatment is filed by the claimant, or a motion is made by the Secretary, not later than one year after the date of the enactment of this Act.

By Mr. SMITH:

S. 1361. A bill to amend the Internal Revenue Code of 1986 to provide that foreign base company shipping income shall include only income from aircraft and income from certain vessels transporting petroleum and related products; to the Committee on Finance.

Mr. SMITH of Oregon. Mr. President, today I am introducing legislation which would deal with a real problem facing our Nation, the decline of our U.S.-owned shipping fleet. A U.S. owned shipping fleet is essential as a matter of national and economic security. My bill would help make U.S. based shipping companies more competitive in the global market.

This is important to our country and to my state. Oregon plays a key role as a facilitator of international commerce. The Port of Portland is one of the most active ports in the world. It is a key link for trade between the United States and the Pacific Rim. In addition to its key role enabling global commerce, Portland is home to U.S. owned shipping companies, shipyards, and numerous support businesses.

As a result of tax-law changes enacted in 1975 and 1986, U.S. shipping companies must pay tax on income earned by subsidiaries overseas immediately rather than when such income is later brought back to the United States. This treatment represents a sharp departure from the generally applicable income tax principle of ''deferral'' and places U.S.-based owners of international fleets at a distinct tax disadvantage compared to their foreign-based competitors.

Controlled foreign corporations engaged in ocean transport are one of the only active businesses that are not eligible for general rule of deferral. My bill would amend the Internal Revenue Code to allow U.S. companies that own foreign-flagged ships to treat income earned by their controlled foreign corporations in the same manner as all other U.S. companies. In short, it would allow American shipping companies to defer the payment of tax on income that they derive from shipping activities outside the United States until that income is repatriated to the United States.

Most foreign-based carriers pay no home-country taxes on income they earn abroad from international shipping. As a result of this competitive imbalance, U.S. companies now hold precious little share of the world shipping marketplace. Indeed, U.S. ownership of international shipping trades dropped precipitously in the aftermath of the 1975 and 1986 tax-law changes. Before 1975, the U.S.-owned share of the world's open-registry shipping fleet stood at 26 percent. By 1986, the U.S. share had dropped to 14 percent. By 1996, the U.S. share had dropped to 5 percent.

Other security concerns also are raised by the decline in U.S. ownership of the international shipping trade. The U.S. military, in times of emergency, relies on the ability to requisition U.S.-owned foreign-flagged tankers, bulk carriers, and other vessels to carry oil, gasoline, and other materials in defense of U.S. interests overseas. These vessels comprise the Effective United States Control, EUSC, fleet. The sharp decline in the EUSC fleet since the 1975 and 1986 tax-law changes, and the resulting adverse strategic consequences, have been confirmed in a recent MIT study conducted for the Navy Department. The study recommended that in the short term, the most practical and cost-effective means of reversing this trend would be to ''revise legislation to reflect tax deferment of income for some or all EUSC vessels.''

U.S. security also depends in no small part on our ability to maintain adequate domestic oil supplies in times of emergency. The United States consumes approximately 19.6 million barrels of oil per day, of which roughly 55 percent, mostly crude, is imported into the United States. It is estimated that 95 percent of all oil imported into the United States by sea is now imported on foreign-owned tankers. This means that one half of every gallon of oil consumed in the United States is carried on foreign-owned vessels. This growing dependence on foreign parties—who may not be sympathetic to U.S. interests—to deliver our oil in times of global crisis is cause for potential alarm. In recent years, two of the largest American shipping companies have been purchased by foreign companies, thereby making their shipping operations more competitive than the remaining American companies.

The time has come for us to make changes in the tax law that will allow our domestic companies to compete fairly in the global marketplace. I urge my colleagues to join me to enact this needed legislation. I ask unanimous consent that the text of the legislation be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1361

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''RAFT (Restore Access to Foreign Trade) Act of 2003''.

SEC. 2. ELIMINATION OF MOST VESSEL SHIPPING INCOME FROM FOREIGN BASE COMPANY INCOME.

(a) FOREIGN BASE COMPANY SHIPPING INCOME TO INCLUDE ONLY INCOME FROM AIRCRAFT AND PETROLEUM VESSELS.—Subsection (f) of section 954 of the Internal Revenue Code of 1986 (relating to foreign base company income) is amended—

(1) by inserting ''petroleum'' before ''vessel'' each place it appears, and

(2) by adding at the end the following new sentence: ''For purposes of this subsection, the term 'petroleum vessel' means any vessel engaged in the carriage of petroleum or related products or byproducts if the controlled group (as defined in section 267(f)(1) without regard to section 1563(b)(2)(C)) of which the taxpayer is a member is engaged principally in the trade or business of exploring for, or extracting, refining or marketing of, petroleum or related products or byproducts.''.

(b) RETENTION OF SEPARATE FOREIGN TAX CREDIT BASKET FOR ALL SHIPPING INCOME.—Subparagraph (D) of section 904(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''(as defined in section 954(f))'' and inserting '', as defined in section 954(f), if references in such section to petroleum vessels included references to all vessels''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years of foreign corporations beginning after December 31, 2002, and to taxable years of United States shareholders (within the meaning of section 951(b) of the Internal Revenue Code of 1986) within which or with which such taxable years of such foreign corporations end.

By Mrs. BOXER:

S. 1362. A bill to authorize the Port Passenger Accelerated Service System (Port PASS) as a permanent program for land border inspection under the Immigration and Nationality Act, and for other purposes; to the Committee on the Judiciary.

Mrs. BOXER. Mr. President, today, I am introducing legislation that will strengthen national security, promote commerce, and provide assistance to our dedicated agents at the border.

Thousands of San Diego and Tijuana residents cross the border every day as commuters, shoppers, or visitors. Unfortunately, our border infrastructure has not kept pace with the increasing

traffic volume, and travelers frequently encounter delays and congestion at the border.

The tragic events of September 11 further intensified these challenges along the border. Increased security measures severely over-extended inspection resources and resulted in longer waiting times for crossing the border.

The Secure Electronic Network for Travelers' Rapid Inspection, SENTRI, program was created to help alleviate the congestion at the border.

SENTRI is a dedicated commuter lane program. It allows pre-screened travelers to move quickly through the inspection process at the United States-Mexican border. After participants pass a background check, they can move more quickly through a dedicated lane.

SENTRI accepts only travelers who pass both an extensive background check to verify their eligibility and a thorough inspection of their vehicle.

Delays at crossing the border were often an hour or more prior to SENTRI But, with the program, the delays for participants are 5 to 15 minutes. Travelers in other lanes also benefit because the prescreened SENTRI crossers move swiftly through the border, reducing the number of motorists using general commuter lanes.

Expediting inspections through SENTRI is actually helping to improve border security, as Customs and Border Patrol agents can focus more attention on nonscreened drivers and passengers.

Unfortunately, SENTRI has become a victim of its own success. SENTRI needs a greater investment of resources to keep up with the current and future demand. Enrollment increased by more than 100 percent after September 11. Currently, prospective applicants must wait approximately 8 months to participate in the program.

For innovative programs, such as SENTRI, to work, we must provide them with the tools and resources they need to succeed. This is why I am introducing the Secure and Fast Entry at the Border Act or SAFE Border Act.

The SAFE Border Act recognizes the contribution of SENTRI to border security and the agents who administer the program. My bill would extend the length of a SENTRI pass from 1 to 2 years—enabling border agents to process more new applicants and reduce the current enrollment wait. The SAFE Border Act also recommends the appointment of dedicated SENTRI staff to expedite application processing, and encourages the creation of a dedicated commuter lane for prescreened, low-risk pedestrian crossers.

In addition, to ensure security at our borders, my legislation bans a person convicted of a felony or under active criminal investigation from participating in the program.

Our agents at the border shoulder an enormous responsibility every day. I believe we owe them the appropriate resources and support they need to carry out their duties.

Our Nation's economic and overall security is heavily linked to smooth and secure border crossings. The SAFE Border Act provides a way for trusted travelers to cross the border securely and quickly.

By Mr. REID:

S. 1363. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service; to the Committee on Energy and Natural Resources.

Mr. REID. Mr. President, as thousands of families look forward to summer vacations at our beautiful national parks, we must address an issue that could one day ruin their experience: privatization of the National Park Service.

The Park Service has worked hard to preserve Nevada's unique landscapes at the Great Basin National Park, Death Valley, and Lake Mead National Recreation Area. Instead of applauding the Park Service for a job well done, the Administration wants to study 1,800 jobs in the Park Service for privatization.

Many of these Park Service jobs have direct contact with visitors to our parks. They not only collect fees and maintain parks but also give directions, fight wildfires when necessary, and provide emergency medical assistance to injured park visitors. They are not required to do these things; they are driven by a love for the parks and a commitment to public service that contractors lack.

Privatizing the Park Service would jeopardize our national parks. Members of the Park Service have a career-long interest in maintaining the parks and perform their jobs because they are dedicated to serving the public. They often go beyond the call of duty to fix a problem in the middle of the night or change a tire for an unlucky park visitor. Can we be sure that a contractor would do the same? No.

In addition, the Park Service receives tens of thousands of hours of volunteer work every year. At the Lake Mead National Recreation Area alone, volunteers provided 92,000 hours of work, the equivalent of 44 full-time employees. Will a contractor find volunteers to provide it with 92,000 hours of assistance. Not likely.

Privatization will waste taxpayer money. Privatization studies cost about $3,000 per position studied, and privatization does not save money.

Nevadans visiting the national parks this summer want members of the Park Service, not profit-minded corporations, enriching their experience by directing them to the famous sites and best kept secrets of our parks.

I oppose privatizing the Park Service because it would hurt Nevadans, endanger our national parks, and waste taxpayer money.

This bill will keep our dedicated Park Service members running our national parks. It stops costly privatization studies and redirects the funds to address the maintenance backlog that President Bush promised to eliminate.

I am committed to protecting our parks, and I am proud to introduce this bill that will ensure that the Park Service can preserve them for generations to come.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1363

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PARK PROFESSIONALS PROTECTION.

(a) SHORT TITLE.—This Act may be cited as the ''Park Professionals Protection Act''.

(b) FINDINGS.—Congress finds the following:

(1) The National Park System is recognized throughout the world as a model for the conservation and enjoyment of natural, scenic, recreational, cultural, and historic resources.

(2) The National Park System would never have achieved such status, nor could the system maintain such status, without the professionalism, dedication, and passion of the men and women of the National Park Service.

(3) Current plans to privatize thousands of jobs within the National Park Service ignore the unique contributions made by the men and women of the National Park Service and threaten to undermine the entire National Park System.

(4) Scarce park operations and maintenance resources are being diverted to pay private consultants to study the current privatization scheme. According to the National Park Service, these studies cost approximately $3000 for each position proposed to be privatized.

(5) Despite the millions of taxpayer dollars diverted to these studies, not a single report has been published documenting any cost savings to be generated by the privatization of park operations.

(6) The current privatization scheme raises serious questions regarding the ability of temporary workers, provided by the lowest bidder, to adequately fulfill the responsibilities of professional National Park Service employees in the areas of conservation, interpretation, emergency fire and rescue, and homeland security.

(7) The current privatization scheme appears to affect minority employees disproportionately, threatening to significantly reduce the number of minority employees within the National Park Service.

(8) Pendency of the current privatization scheme is having detrimental impacts on the morale of current employees and is discouraging high quality candidates from applying for positions within the National Park Service.

(c) PROHIBITION.—Notwithstanding any other provision of law, the Secretary is prohibited from studying or implementing any plan to privatize, divest, or transfer any part of what is, as of the date of the enactment of this section, the mission, function, or responsibility of the National Park Service.

(d) REALLOCATION OF FUNDS.—Notwithstanding any other provision of law, the Secretary shall withhold any funds currently dedicated to the activities prohibited under subsection (c) and shall reallocate those funds to the operations and maintenance accounts within the National Park Service.

(e) NO EFFECT ON CERTAIN PLANS.—Nothing in this section shall affect the authority, as of the date of the enactment of this section, of a National Park Service Superintendent to develop and implement concessions management plans and commercial services plans covering, in whole or in part, the area managed by that Superintendent.

(f) SECRETARY DEFINED.—The term ''Secretary'' means the Secretary of the Interior and any person employed by the Secretary of the Interior in any capacity.

By Ms. MURKOWSKI:

S. 1364. A bill to amend the Alaska National Lands Conservation Act to authorize the payment of expenses after the death of certain Federal employees in the State of Alaska; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, on the morning following the annual candlelight vigil to honor fallen law enforcement officers, I came to the floor to speak about three brave Alaskans whose names were inscribed on the National Law Enforcement Officers' Memorial at Judiciary Square this year. One of these brave Alaskans was a National Park Service ranger who lost his life when the aircraft he was piloting crashed in a remote part of Alaska. Today, I am introducing legislation which I hope will help the surviving family members of this ranger in their recovery from this tragic loss and provide authority for the Federal Government to help the surviving family members of other similarly situated Federal employees should a similar tragedy occur in the future.

This ranger I am speaking about was assigned to the Katmai National Park and Preserve in the Bristol Bay region of Alaska and lived in the community of Naknek. Naknek is not connected to the rest of North America by road. It is what we in Alaska call a ''bush'' community. But it was home to the ranger and became the adopted home of his widow who did not grow up in the area. The ranger about whom I am speaking was hired under a special hiring authority in the Alaska National Interest Lands Conservation Act, ANILCA, which authorizes the Federal land managers to extend a hiring preference to those with special knowledge about a Conservation System Unit. He was regarded as a ''local hire.''

Under the Federal Travel Regulation, when a federal employee dies outside of the Continental United States, the Federal Government will reimburse the members of his or her household for the cost of relocating to their permanent residence. Alaska is regarded as ''outside of the Continental United States'' under this regulation.

Thus, if the National Park Service ranger who died in the line of duty came from the Lower 48 before being assigned to the Katmai National Park and Preserve then the Federal Government, as I read the regulation, could reimburse the surviving family members for the cost of relocating to Anchorage. This cost can be fairly substantial since one cannot hire a moving van to ship the personal effects from South Naknek to Anchorage. There are no roads which connect the bush village of South Naknek to Anchorage. The personal effects need to be transported by air.

However, if the deceased employee is a local hire employee, the Federal Travel Regulation does not authorize the Federal Government to reimburse the surviving family members for their relocation cost because the deceased employee's hometown is deemed to be the local hire location. This works an inequity where, as in the present case, the deceased employee's surviving spouse does not have ties to the duty station community, but rather to another community in Alaska. In this instance, the surviving spouse desires to relocate to Anchorage, which is Alaska's largest city, and continue to raise her three children there.

The legislation that I am introducing today is intended to cure this inequity. It would amend ANILCA, the same legislation which contains the local hire authority, to provide that if a local hire employee dies in the line of duty, the Federal Government will reimburse the surviving immediate family for the cost of transporting the remains to a location in Alaska of their choosing and will also relocate the immediate family members to a community in the State of Alaska which is selected by the surviving head of household. I think that this is the least we can do for the survivors of local hire employees who go to work everyday in the harsh climate and conditions of bush Alaska but sadly sometimes do not return home.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1364

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PAYMENT OF EXPENSES AFTER THE DEATH OF CERTAIN FEDERAL EMPLOYEES IN THE STATE OF ALASKA.

Section 1308 of the Alaska National Interest Lands Conservation Act (16 U.S.C. 3198) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

''(c) PAYMENT OF EXPENSES AFTER DEATH OF AN EMPLOYEE.—

''(1) DEFINITION OF IMMEDIATE FAMILY MEMBER.—In this subsection, the term ''immediate family member'' means a person related to a deceased employee that was a member of the household of the deceased employee at the time of death.

''(2) PAYMENTS.—If an employee appointed under the program established by subsection (a) dies in the performance of any assigned duties on or after October 1, 2002, the Secretary may—

''(A) pay reasonable expenses for the preparation and transportation of the remains of the deceased employee to a location in the State of Alaska which is selected by the surviving head of household of the deceased employee;

''(B) pay reasonable expenses for transporting immediate family members and the baggage and household goods of the deceased employee and immediate family members to a community in the State of Alaska which is selected by the surviving head of household of the deceased employee.''.

By Mr. MCCONNELL (for himself, Mr. KYL, and Mr. LEAHY):

S. 1365. A bill to provide increased foreign assistance for Cambodia under certain circumstances, and for other purposes; to the Committee on Foreign Relations.

Mr. MCCONNELL. Mr. President, today, along with my colleagues Senators KYL and LEAHY, I offer the ''Cambodia Democracy and Accountability Act of 2003''. This Act is particularly timely, given that national elections are scheduled in that country on July 27th.

Cambodia is on its third round of parliamentary elections since the 1991 Paris Peace Accords, with previous elections having been funded by the United Nations in 1993 and by the Cambodian governments in 1998. Despite the billions of dollars spent on elections in that country—over $2 billion by the U.N. alone—there has yet to be a credible poll that accurately reflects the will of the Cambodian people.

My colleagues will remember that the U.N.-sponsored elections resulted in a large voter turnout—but also an unworkable power sharing deal brokered between the winning royalist FUNCINPEC party and the hard line Cambodian People's Party, CPP, that quickly dissolved into open hostilities, including a bloody grenade attack against a peaceful, pro-democracy rally and a CPP sponsored coup d'etat in 1997.

The debilitating hangover from this coup—destroyed party offices, dead activists, and a palpable climate of fear and repression—undermined prospects for free and fair elections in 1998 even before the first ballots were cast.

Fatigued and frustrated, the international community found it expedient to endorse the flawed elections, even as students and Buddhist monks erected a ''democracy square'' in Phnom Penh to protest the polls. A CPP crackdown left many of these peaceful protestors killed, beaten or harassed.

It is time that Prime Minister Hun Sen—as the self-proclaimed strongman of Cambodia—is held accountable for the murder of political activists, Buddhist monks, civilians, and students. There is no rule of law, if the leaders of the government are not subject to it.

A second ''coalition'' government between royalists and hard liners was cobbled together in the aftermath of the 1998 elections. This time, there was no pretext of power sharing, and for the past 5 years CPP has been firmly and completely in control of the country.

Nevertheless, in the months and weeks before the upcoming July elections, the political marriage between FUNCINPEC and CPP is fraying. In an

effort to harass and intimidate his opponents, in late January Prime Minister Hun Sen whipped up nationalistic sentiment against Thailand, let loose the so-called Pagoda Boys, government-paid thugs, and destroyed $50 million worth of Thai public and private interests in Phnom Penh.

Despite frantic pleas for assistance, the Thai ambassador and other diplomatic personnel escaped injury by scaling the embassy's walls and scurrying to safety. In the aftermath of the riots, Hun Sen arrested and intimidated students, independent broadcasters, and political activists. A senior opposition figure sought—and was granted— refuge in the U.S. Embassy.

In February, former royalist parliamentarian Om Radsady was gunned down in a mafia-style murder in Phnom Penh. Well liked and respected by his colleagues from all Cambodian political parties, Radsady's assassination sent a not so subtle message that no one is immune from the black hand of CPP.

It is time Hun Sen is held accountable for his complicity in actions that grossly violate international and domestic laws, and the human rights and dignity of the people of Cambodia.

The fundamental question facing the Cambodian people today is whether the July 27th elections will be a meaningful exercise in democracy, or another lost opportunity to chart a new course for that beleaguered country.

Last week, Prime Minister Hun Sen assured Secretary of State Colin Powell that Cambodia would hold free and fair elections. Secretary Powell should not be duped by these hollow promises. A preponderance of evidence suggests that CPP is actively trying to steal the elections before July 27th: political activists continue to be murdered and intimidated, creating a chilling tone of fear and repression; the CPP continues to directly influence and manipulate the election machinery, with members of the National Election Commission, NEC, nominated in a closed manner by the co-Ministers of Interior and the NEC already failing to investigate allegations of election improprieties; and, opposition political parties continue to lack access to media, with several broadcast outlets in Cambodia unwilling to sell air time to CPP's challengers.

Let me take a moment to describe what the Cambodian Democracy and Accountability Act does—and does not—do.

The Act provides additional foreign assistance to Cambodia—an increase by half (or $21.5 million) over the fiscal year 2004 budget request of $43 million—if new leadership has been elected in free and fair elections, and if Hun Sen is no longer Prime Minister. It has been apparent to me that Hun Sen has long been part of Cambodia's problems—and not part of the solution.

The Act does not preclude the Cambodian people from voting for the political party of their choice. Ballot secrecy must be ensured—as well as transparency in the process of vote counting and tabulation—in order that the will of the Cambodian people is accurately expressed. It is my fear that CPP pre-election chicanery may already have violated the integrity of the election process.

If I wanted to interfere with the elections I would have offered legislation that restricts all assistance to Cambodia unless a specific political party or parties was elected. This Act does not do this. It does not cut any assistance—not a single penny—to Cambodia included in the fiscal year 2004 budget request. It simply provides that if the major obstacle to democracy and development in the country—namely Prime Minister Hun Sen—is out of power, additional foreign aid will be forthcoming.

It is important to recall that Hun Sen's coup resulted in severe restrictions on assistance to Cambodia—that continue to this day. If given an opportunity through free and fair elections, the Cambodian people will make the right choices that will ensure a dawn for development in that country.

Why will they make the right choice? Over the many decades he has been in power, Hun Sen has ruled Cambodia through violence, fear and repression. Under his watch, the country has become a haven for sexual predators and pedophiles, the criminal underworld, and international terrorists. Hun Sen has repeatedly abused the most basic of freedoms protected by the Cambodian Constitution, attacked his political opposition, and perpetuated a climate of impunity that stifles the advancement of freedom and free markets.

And he has never—not once—been held accountable for his actions.

In addition to increasing foreign assistance under certain conditions, the Act restricts assistance to a Khmer Rouge tribunal unless the President determines that, among other things, the tribunal is supported by democratic Cambodian political parties and is not under the control or influence of the CPP. It also requires the Federal Bureau of Investigations to resume its investigation of the March 30, 1997 grenade attack against opposition leader Sam Rainsy that killed and injured scores of Cambodians.

I should remind my colleagues that American democracy worker Ron Abney was injured in this act of terrorism, reportedly carried out by the CPP. Ron—and all the victims of this attack—are still waiting for justice.

Secretary Powell wrote in a June 24 op-ed that Zimbabwean dictator Robert Mugabe's ''time has come and gone.'' As democracy is similarly under siege in both Zimbabwe and Cambodia, dictator Hun Sen's time has also come and gone.

By Mr. ALLARD (for himself, Mr. FEINGOLD, and Mr. CRAPO):

S. 1366. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Environment and Public Works.

Mr. ALLARD. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1366

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Chronic Wasting Disease Financial Assistance Act of 2003''.

SEC. 2. DEFINITION AND FINDINGS.

(a) CHRONIC WASTING DISEASE DEFINED.—In this Act, the term ''chronic wasting disease'' means the animal disease afflicting deer and elk that—

(1) is a transmissible disease of the nervous system resulting in distinctive lesions in the brain; and

(2) belongs to the group of diseases known as transmissible spongiform encephalopathies, which group includes scrapie, bovine spongiform encephalopathy, and Cruetzfeldt-Jakob disease.

(b) FINDINGS.—Congress finds the following:

(1) The States retain undisputed primacy and policy-making authority with regard to wildlife management, and nothing in this Act interferes with or otherwise affects the primacy of the States in managing wildlife generally, or managing, surveying, and monitoring the incidence of chronic wasting disease in animal populations.

(2) Chronic wasting disease is a fundamental threat to the health and vibrancy of deer and elk populations, and the increased occurrence of chronic wasting disease in the United States necessitates government action to manage and eradicate this lethal disease.

(3) As the States and tribal government move to manage existing incidence of chronic wasting disease and insulate non-infected wild cervid populations from the disease, it is appropriate for the Federal Government to support their efforts with financial assistance.

SEC. 3. STATE CHRONIC WASTING DISEASE MANAGEMENT CAPACITY BUILDING GRANTS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to State wildlife management agencies to assist States in developing and implementing long term management strategies to address chronic wasting disease in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of a State whose comprehensive wildlife conservation plan include chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) States in which chronic wasting disease has been detected and States located adjacent or in proximity to States in which chronic wasting disease has been detected.

(2) States that have expended State funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to those States

that have shown the greatest financial commitment to managing, monitoring, surveying, and researching chronic wasting disease.

(3) States with comprehensive and integrated policies and programs focused on chronic wasting disease management between involved State wildlife and agricultural agencies and tribal governments, with additional priority given to States that have integrated the programs and policies of all involved agencies related to chronic wasting disease management.

(4) States that are seeking to develop a rapid response capacity to address outbreaks of chronic wasting disease, whether occurring in States in which chronic wasting disease is already found or States with first infections, for the purpose of containing the disease in any new area of infection.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $7,500,000 to carry out this section.

SEC. 4. GRANTS FOR STATES WITH CHRONIC WASTING DISEASE OUTBREAKS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to State wildlife management agencies to assist States in responding to chronic wasting disease outbreaks in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of a State whose comprehensive wildlife conservation plan include chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) State expenditures on chronic wasting disease management, monitoring, surveillance, and research in response to management of an on-going outbreak.

(2) The number of chronic wasting disease cases detected in the State.

(3) The wild cervid population of the State.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 to carry out this section.

SEC. 5. TRIBAL CHRONIC WASTING DISEASE MANAGEMENT GRANTS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to tribal wildlife management agencies to assist Indian tribes in developing and implementing long term management strategies to address chronic wasting disease in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of an Indian tribe whose comprehensive wildlife conservation plan include chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) Tribal governments managing lands on which cervids with chronic wasting disease have been detected, or managing lands located adjacent or in proximity to lands on which cervids with chronic wasting disease have been detected.

(2) Tribal governments that have expended tribal funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to tribal governments that have shown the greatest financial commitment to managing, monitoring, and surveying chronic wasting disease.

(3) Tribal governments with cooperative arrangements with Federal and State wildlife and agricultural agencies and State governments, with additional priority given to tribal governments that are working with other involved agencies on issues of chronic wasting disease management.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 to carry out this section.

SEC. 6. ADMINISTRATION.

The Secretary of the Interior shall carry out this Act acting through the Director, United States Fish and Wildlife Service. Funds appropriated to carry out this Act shall be administered through the Federal Assistance Program in the United States Fish and Wildlife Service. Not more than three percent of such funds may be expended for administrative expenses of the United States Fish and Wildlife Service to carry out this Act.

Mr. FEINGOLD. Mr. President, I am pleased to join with my colleague from Colorado, Mr. ALLARD, as a cosponsor of the Chronic Wasting Disease Financial Assistance Act of 2003. This legislation is similar to legislation, S. 1036, the Chronic Wasting Disease Support Act of 2003, that we introduced earlier this year.

The House Resources Committee held a hearing on June 19, 2003 on the issue of chronic wasting disease, or CWD. At that hearing, state agency representatives argued strongly that Congress should create a new grant program to provide assistance to states for the management of CWD. They also expressed an interest in having those funds distributed using an existing distribution mechanism. This legislation responds directly to these comments. In total, the bill directs the U.S. Fish and Wildlife Service to provide $20.5 million in Federal grants to State and tribal governments for CWD management in wild deer and elk, $10.5 million more in resources than were included in the bill Senator ALLARD and I introduced earlier this year.

The bill creates three new Federal CWD grant programs. The first program is a new nationwide CWD capacity grant, authorized at a total of $7.5 million. This program would provide grants to States so that they can fund CWD management programs. Preference would be given to States with comprehensive and integrated chronic wasting disease management programs involving all relevant state agencies.

The second grant program would provide additional $10 million in grant assistance to states like Colorado and Wisconsin that already have detected chronic wasting disease in their wild deer and elk. These States need additional help. Wisconsin has undertaken significant measures to combat CWD at significant expense, and this program acknowledges that outbreaks are expensive to manage and require Federal financial assistance.

Finally, the bill would create a third $3 million grant program to provide CWD management grants directly to tribal governments. To be eligible for these programs, States and tribes are given the ability under the bill to use an existing mechanism, the U.S. Fish and Wildlife Service Federal Assistance Act procedures to expedite the receipt of grant funds.

This bill is needed because State wildlife departments and tribal governments do not have the financial resources to adequately confront the problem. Their resources are spread too thin as they attempt to prevent the disease from spreading. Federal help in the form of management funding is urgently needed. Federal funding will help States and tribes to protect and safeguard our valued wild deer and elk from this disease.

I look forward to working with the Senate to secure passage of this measure. This is a good bill, and it deserves the Senate's support.

By Mr. MCCONNELL (for himself, Mr. BAYH, and Mr. FITZGERALD):

S. 1367. A bill to amend the Richard B. Russell National School Act to establish programs to promote increased consumption of milk in schools and to improve the nutrition and health of children; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. MCCONNELL. Mr. President, I rise today to introduce a very important piece of legislation that could provide great benefits for the health of our young people while simultaneously strengthening the future viability of dairy producers throughout the United States.

My bill, the Child Nutrition Improvement Act of 2003, would provide incentives for schools to encourage the consumption of milk as part of the school lunch program and supply needed flexibility for schools to offer a wide variety of milk products and flavors.

There is no doubt that the eating habits we develop when we are young affect our habits and nutritional choices for the rest of our lives. The school lunch program has provided a key tool in promoting healthy eating habits among young people, which have both health and educational benefits.

Milk has been a critical component of the school lunch program because it is the principal source of calcium and a leading source of several other important nutrients in our diet. That was true when the federal program began in 1946 and it is still true today.

With 9 out of 10 teenage girls and 7 out of 10 teenage boys currently not getting enough calcium, milk's important is perhaps greater today than ever before. Serving milk with the school lunch is a critical step in addressing the calcium crisis. Federal child health experts who are on the frontlines fighting the calcium crisis recognize milk's central role in addressing the problem. Study after study, emphasize the need for growing children and teens to consume more milk for healthy bones, and the American Academy of Pediatrics has urged its members to recommend their patients get enough milk, cheese, yogurt and other calcium rich foods to help build bone mass.

As a result of these recommendations, we have seen a push for more milk in more places in school, like vending machines and school stores. There's a real concern about nutritious choices for school children, and many

local school districts and state legislatures are pushing to add more healthful beverage choices like milk.

A large school vending test in 2001 demonstrated that kids will eagerly buy milk from vending machines in schools when it is offered. The test was heralded by school nutritionists and helped stimulate nationwide interest in getting milk vending machines into more schools.

A pilot test conducted in 146 schools with 100,000 students showed dramatic increases in milk consumption—15 percent in elementary schools and 22 percent in secondary schools—when simple improvements were made in the way milk was packaged and presented to students. The milk was served colder and kids loved the addition of a third flavor, it was usually strawberry. No only did kids drink more milk, more kids ate in the cafeteria. That meant they not only got milk, they also got improved nutrition through greater intake of vegetables, fruits and other nutritionally important foods.

Milk has an unsurpassed nutrient package for young children and teens. Milk has nine essential vitamins and minerals, including calcium, vitamins A, D and B12, protein, potassium, riboflavin, niacin and phosphorus. These nutrients are critical to good health and the prevention of chronic disease. In addition, it is the primary way that growing children get the calcium they need. In fact, according to the U.S. Department of Agriculture about 75 percent of the calcium in our food supply comes from milk and foods made with milk. By about age 20, the average young person has acquired about 98 percent of his or her skeletal mass. Building strong bones during childhood and adolescence is one of the best defenses against developing osteoporosis later in life.

In addition to the bone-building benefits of milk, research indicates that a diet rich in low-fat milk may help reduce the risk of high blood pressure and heart disease and help prevent breast cancer, colon cancer and even help in the fight against obesity.

Milk's role in a nutritious diet has long been noted by the nutrition and science community, including the American Academy of Pediatrics, the American Dietetic Association, the National Institute of Child Health and Human Development, the National Osteoporosis Foundation, the U.S. Department of Agriculture, and many other reputable health organizations.

As I have already mentioned, government statistics indicate that we have a calcium crisis among our children and youth. Nearly 90 percent of teenage girls and almost 70 percent of teenage boys fail to get enough calcium in their diets. During the teen years nearly half of all bone is formed and about 15 percent of your adult height is added. As a national health priority, for proper growth and development, we need to be doing all we can to encourage our children and youth to drink milk, and that is the goal of the legislation I am introducing today.

I ask my colleagues for your support of this important piece of legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1367

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Child Nutrition Improvement Act of 2003''.

SEC. 2. CONSUMPTION OF MILK IN SCHOOLS.

(a) FLUID MILK.—

(1) IN GENERAL.—Section 9(a) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(a)) is amended by striking paragraph (2) and inserting the following:

''(2) FLUID MILK.—

''(A) IN GENERAL.—Lunches served by schools participating in the school lunch program under this Act—

''(i) shall offer students fluid milk; and

''(ii) shall offer students a variety of flavored and unflavored milk, as determined by the school.

''(B) FLUID MILK PRODUCTS.—A school or institution that participates in the school lunch program under this Act—

''(i) may offer a la carte fluid milk products to be sold in addition to and, at the option of the school, adjacent to fluid milk offered as part of a reimbursable meal; and

''(ii) shall not directly or indirectly restrict the sale or marketing of fluid milk products by the school (or by a person approved by the school) at any time or any place—

''(I) on the school premises; or

''(II) at any school-sponsored event.''.

(2) APPLICATION.—The amendment made by paragraph (1) applies to an agreement or contract entered into on or after the date of enactment of this Act.

(b) INCREASED CONSUMPTION OF MILK IN SCHOOLS.—Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760) is amended by adding at the end the following:

''(q) INCREASED CONSUMPTION OF MILK IN SCHOOLS.—

''(1) IN GENERAL.—To encourage healthier nutritional environments in schools and institutions receiving funds under this Act and the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.) (other than section 17 of that Act (42 U.S.C. 1786)), the Secretary shall establish a program under which any such school or institution may (in accordance with paragraph (3)) receive an increase in the reimbursement rate for free and reduced price meals otherwise payable under this Act and the Child Nutrition Act of 1966, if the school or institution implements a plan for improving the nutritional value of meals consumed in the school or institution by increasing the consumption of fluid milk in the school, as approved by the Secretary in accordance with criteria established by the Secretary.

''(2) PLANS.—

''(A) IN GENERAL.—For purposes of the program established under paragraph (1), the Secretary shall establish criteria for the approval of plans of schools and institutions for increasing consumption of fluid milk.

''(B) CRITERIA.—An approved plan may—

''(i) establish targeted goals for increasing fluid milk consumption throughout the school or institution or at school or institution activities;

''(ii) improve the accessibility, presentation, positioning, or promotion of fluid milk throughout the school or institution or at school or institution activities;

''(iii) improve the ability of a school or institution to tailor the plan to the customs and demographic characteristics of—

''(I) the population of the school or institution; and

''(II) the area in which the school or institution is located; and

''(iv) provide—

''(I) packaging, flavor variety, merchandising, refrigeration, and handling requirements that promote the consumption of fluid milk; and

''(II) increased standard serving sizes for fluid milk consumed in middle and high schools.

''(C) ADMINISTRATION.—In establishing criteria for plans under this subsection, the Secretary shall—

''(i) take into account relevant research; and

''(ii) consult with school food service professionals, nutrition professionals, food processors, agricultural producers, and other groups, as appropriate.

''(3) REIMBURSEMENT RATES AND INCENTIVES.—

''(A) IN GENERAL.—For purposes of administering the program established under paragraph (1), the Secretary shall annually provide reimbursement rates and incentives for free and reduced price meals otherwise payable under this Act and the Child Nutrition Act of 1966 of not less than 2 cents and not more than 10 cents per meal, to reflect the additional costs incurred by schools and institutions in increasing the consumption of fluid milk under the program.

''(B) CRITERIA.—The Secretary may vary the increase in reimbursement rates and incentives for free and reduced price meals based on the degree to which the school or institution adopts the criteria established by the Secretary under paragraph (2).''.

SEC. 4. IMPROVED NUTRITION AND PHYSICAL ACTIVITY LEVEL OF CHILDREN.

Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760) (as amended by section 2(b)) is amended by adding at the end the following:

''(r) IMPROVED NUTRITION AND PHYSICAL ACTIVITY LEVEL OF CHILDREN.—

''(1) DEFINITION OF HEALTHY SCHOOL ENVIRONMENT PROGRAM.—In this subsection, the term 'healthy school environment program' means a program that—

''(A) is designed to improve the environment of a school with respect to the nutrition and physical activity level of children enrolled in the school; and

''(B) includes steps to improve and make available healthy food choices (including fruits, vegetables, and dairy products).

''(2) PROGRAM.—The Secretary shall carry out a program to provide grants to schools that implement healthy school environment programs.

''(3) ADMINISTRATION.—In carrying out the program, the Secretary may enter into cooperative agreements with—

''(A) nonprofit organizations;

''(B) educational and scientific institutions;

''(C) Federal, State, and local agencies; and

''(D) other entities that contribute funds or in-kind services for the program.

''(4) ACCEPTANCE OF FUNDS.—Notwithstanding any other provision of law, the Secretary may accept funds from an entity referred to in paragraph (3) solely for use in carrying out the program under this subsection.''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 187—EXPRESSING THE SENSE OF THE SENATE REGARDING THE CENTENARY OF THE RHODES SCHOLARSHIPS IN THE UNITED STATES AND THE ESTABLISHMENT OF THE MANDELA RHODES FOUNDATION

Mr. LUGAR (for himself, Mr. SARBANES, and Mr. FEINGOLD) submitted the following resolution; which was:

S. RES. 187

Whereas the Rhodes Scholarships, the oldest international fellowships, were initiated after the death of Cecil Rhodes in 1902, and now bring outstanding students from the United States, Australia, Bangladesh, Bermuda, Canada, the Commonwealth Caribbean, Germany, Hong Kong, India, Jamaica, Kenya, Malaysia, New Zealand, Pakistan, Singapore, South Africa, Uganda, Zambia, and Zimbabwe to the University of Oxford;

Whereas the first American Rhodes Scholars were elected in 1904, and since that time distinguished American Rhodes alumni have included over 20 members of Congress, a President of the United States, 3 Supreme Court justices, cabinet members, military leaders, 80 heads of colleges or universities, and prominent artists, scientists, and business people;

Whereas the Mandela Rhodes Foundation, a partnership between the Rhodes Trust and the Nelson Mandela Foundation, was established in February, 2002;

Whereas after a lifetime of struggle against apartheid and the momentous challenge of governing the new South Africa as its first democratically elected President, Nobel Peace Prize Laureate Nelson Rolihlahla Mandela continues to be devoted to building a society characterized by justice and opportunity in the Republic of South Africa;

Whereas President Mandela's efforts have manifested themselves in the work of the Nelson Mandela Children's Fund, established in the wake of President Mandela's pledge to devote ⅓ of his Presidential salary to projects aimed at improving the quality of life of South Africa's disadvantaged children; and

Whereas in Cape Town in February, 2002, President Mandela noted that the partnership between the Rhodes Trust and the new Mandela Foundation signals ''the closing of the circle and the coming together of 2 strands in our history'': Now, therefore, be it

Resolved, That the Senate—

(1) celebrates the centenary of the Rhodes Scholarships in the United States;

(2) welcomes the establishment of the Mandela Rhodes Foundation, which embodies the spirit of reconciliation and shared commitment that is one of South Africa's greatest assets;

(3) shares the Foundation's commitment to support initiatives aimed at increasing educational opportunities, fostering leadership, and promoting human resource development throughout Africa; and

(4) affirms the support of the United States for these worthy goals throughout the sub-Saharan region, and asserts that the pursuit of these goals is in the shared interest of the American and African people.

SENATE RESOLUTION 188—HONORING MAYNARD HOLBROOK JACKSON, JR. FORMER MAYOR OF THE CITY OF ATLANTA, AND EXTENDING THE CONDOLENCES OF THE SENATE ON HIS DEATH

Mr. CHAMBLISS (for himself and Mr MILLER) submitted the following resolution; which was:

S. RES. 188

Whereas the Honorable Maynard Holbrook Jackson, Jr. was born on March 23, 1938, in Dallas, Texas, and at the age of 14 entered Morehouse College as a Ford Foundation Early Admission Scholar;

Whereas the Honorable Maynard Holbrook Jackson, Jr. graduated *cum laude* from North Carolina Central University School of Law;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became the first African–American Vice Mayor of the City of Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. proved to be a gifted and brilliant political leader, and he later became the first African–American Mayor of the City of Atlanta;

Whereas, during his years in office, the Honorable Maynard Holbrook Jackson, Jr. was the catalyst for the design of a $400 million terminal at Atlanta's Hartsfield International Airport;

Whereas the Honorable Maynard Holbrook Jackson, Jr. helped to secure Atlanta's selection as the site of the 1996 Summer Olympics;

Whereas the Honorable Maynard Holbrook Jackson, Jr. served as president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became Chair of the National Voting Rights Institute of the Democratic National Committee;

Whereas the Honorable Maynard Holbrook Jackson, Jr. established the American Voters League, a nonpartisan organization committed to increasing voter turnout;

Whereas upon being elected Mayor of Atlanta, the Honorable Maynard Holbrook Jackson, Jr. began encouraging and fostering interracial understanding in Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a strong supporter of affirmative action, civil rights, and the expansion of social and economic gains for minorities;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a great champion for diversity, inclusion, and fairness–not just in government and business, but also in all areas of life;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a wonderful human being who never wavered from the principles that guided his life and career;

Whereas the efforts of the Honorable Maynard Holbrook Jackson, Jr. on behalf on the City of Atlanta and all Americans earned him the esteem and high regard of his colleagues; and

Whereas the untimely death of the Honorable Maynard Holbrook Jackson, Jr. has deprived his community, the City of Atlanta, the state of Georgia, and the entire Nation of an outstanding leader: Now, therefore, be it: Now, therefore, be it

Resolved: That the Senate—

(1) honors the life and accomplishments of the Honorable Maynard Holbrook Jackson Jr.;

(2) recognizes the legendary compassion exhibited by the Honorable Maynard Holbrook Jackson, Jr. as a civil rights leader; and

(3) extends its condolences to the Jackson family and the City of Atlanta on the death of a remarkable man.

SENATE RESOLUTION 189—ELECTING DOCTOR BARRY C. BLACK, OF BALTIMORE, MARYLAND, AS CHAPLAIN OF THE UNITED STATES SENATE

Mr. FRIST (for himself and Mr. DASCHLE) submitted the following resolution; which was:

S. RES. 189

Resolved, That Doctor Barry C. Black, of Baltimore, Maryland, be, and he is hereby, elected Chaplain of the Senate, effective Monday, July 7, 2003.

SENATE RESOLUTION 190—COMMENDING GENERAL ERIC SHINSEKI OF THE UNITED STATES ARMY FOR HIS OUTSTANDING SERVICE AND COMMITMENT TO EXCELLENCE

Mr. AKAKA (for himself, Mr. INHOFE, Mr. WARNER, Mr. LEVIN, Mrs. MURRAY, Mr. DODD, Ms. LANDRIEU, Mr. PRYOR, Mr. DASCHLE, Mr. BIDEN, Mr. KENNEDY, Mr. FEINGOLD, Mr. DURBIN, Mr. NELSON of Nebraska, Mr. NELSON of Florida, Mr. REED, Mr. CHAMBLISS, Ms. CANTWELL, Mr. SARBANES, Mrs. CLINTON, Mr. ROBERTS, Mr. LAUTENBERG, Mr. LIEBERMAN, Mr. DAYTON, Ms. MURKOWSKI, Mr. INOUYE, Mr. HAGEL, Ms. COLLINS, and Mr. STEVENS) submitted the following resolution; which was:

S. RES. 190

Whereas General Eric Shinseki, the Army's 34th Chief of Staff, retired in June 2003, from active military duty after 37 distinguished years of service;

Whereas General Shinseki, a native of Hawaii, graduated from the United States Military Academy, West Point, in 1965 and served in a variety of assignments, including 2 combat tours in Vietnam, and was wounded twice in combat while serving his country;

Whereas General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with oak leaf clusters), Bronze Star Medal with ''V'' Device (with 2 oak leaf clusters), Purple Heart (with oak leaf cluster), Meritorious Service Medal (with 2 oak leaf clusters), Air Medal, Army Commendation Medal (with oak leaf cluster), Army Achievement Medal, Parachutist Badge, Ranger Tab, Office of the Secretary of Defense Identification Badge, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge;

Whereas General Shinseki has spent the last 4 years of his career in the highest position attainable in the Army and has proven himself a tremendous leader who has demonstrated unselfish devotion to this Nation and the soldiers he leads;

Whereas General Shinseki focused the Army on improved readiness in preparation for war and transformed the Army into the lean, agile, lethal fighting force that achieved victories during Operations Enduring Freedom and Iraqi Freedom;

Whereas General Shinseki provided the vision to set the Army on a path of transformation that will provide the Nation with an Army that is more lethal, agile, deployable, and flexible; capable of fighting and winning this Nation's wars in all future threat environments.

Whereas General Shinseki exemplifies the trademark characteristics exhibited by all

great leaders and is a remarkable man of integrity, courage, and honor;

Whereas General Shinseki is an American hero who has been selfless in his service to his country through war, peace, and personal trial, and epitomizes the spirit of aloha; and

Whereas John F. Kennedy, the 35th President of the United States once said, ''When at some future date the high court of history sits in judgment of each one of us—recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to 4 questions—were we truly men of courage . . . were we truly men of judgment . . . were we truly men of integrity . . . were we truly men of dedication?'' and whereas when history looks back at the Army's 34th Chief of Staff, it will be clear that this was truly a man of courage, judgment, integrity, and dedication: Now, therefore, be it

Resolved,

SECTION 1. COMMENDATION.

The Senate—

(1) thanks General Eric Shinseki of the United States Army on behalf of a grateful Nation; and

(2) commends General Eric Shinseki for his extraordinary dedication to service to this great country and for his lifetime of commitment to excellence.

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to General Eric Shinseki.

Mr. AKAKA. Mr. President, I rise today to honor a great American hero, General Eric Shinseki, the Army's 34th Chief of Staff. General Shinseki, a native of Hawaii, attained the Army's highest position as the Army's Chief of Staff in June 1999 and retired in June 2003.

Ric Shinseki graduated from the United States Military Academy, West Point, in 1965. He served two combat tours in Vietnam and was wounded twice in combat. Throughout his 37 years of service to this country, he has given his personal best, serving with great pride and dignity. His legacy to this Nation will live on for years to come.

Over the span of his career, I've watched his progress as a soldier and was privileged to participate in his promotion ceremony to Colonel. At that time, I thought he had a stellar career as a ''soldier's soldier.'' I was very proud to witness his four years of service as the Army's Chief of Staff. He was the perfect soldier to lead our Army into the 21st century.

This remarkable man and distinguished decorated soldier set a new standard for the Army. With extraordinary vision, he transformed the Army into an agile, lean, flexible, and lethal fighting force. This man of honor, integrity, and courage set a higher standard for all to follow, all while embodying the spirit of aloha. With his deep sense of pride and dedication to service, he made our Army stronger, one able to achieve swift victories during Operations Enduring Freedom and Iraqi Freedom.

As I quoted in the Senate Resolution, President John F. Kennedy once said, ''When at some future date the high court of history sits in judgment of each one of us—recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to four questions—were we truly men of courage ... were we truly men of judgment ... were we truly men of integrity ... were we truly men of dedication?'' When history looks back at the Army's 34th Chief of Staff, it will be clear that this was truly a man of courage, judgment, integrity, and dedication.

General Shinseki is to be commended for his patriotism, unwavering commitment to this Nation, and his meritorious service to this country.

SENATE CONCURRENT RESOLUTION 56—EXPRESSING THE SENSE OF THE CONGRESS THAT A COMMEMORATIVE POSTAGE STAMP SHOULD BE ISSUED HONORING GUNNERY SERGEANT JOHN BASILONE, A GREAT AMERICAN HERO

Mr. CORZINE (for himself, Mr. WARNER, Mr. LAUTENBERG, and Mrs. CLINTON) submitted the following concurrent resolution; which was referred to the Committee on Governmental Affairs:

S. CON. RES. 56

Whereas Gunnery Sergeant John Basilone was born in 1916 in Buffalo, New York, son of Salvatore and Dora Basilone, one of 10 children;

Whereas John Basilone was raised and educated in Raritan, New Jersey;

Whereas, at the age of 18, John Basilone enlisted in the United States Army, principally seeing garrison service in the Philippines;

Whereas, after his honorable discharge in 1937, Sergeant Basilone, known by his comrades as ''Manila John'', returned to Raritan;

Whereas, seeing the storm clouds of war hovering over the Nation, and believing that his place was with this country's fighting forces, Sergeant Basilone enlisted in the United States Marine Corps in July 1940;

Whereas, on October 24 and 25, 1942, on Guadalcanal, Solomon Islands, Sergeant Basilone was a member of ''C'' Company, 1st Battalion, 7th Regiment, 1st Marine Division, and was in charge of 2 sections of heavy machine guns defending a narrow pass that led to Henderson Airfield;

Whereas, although Sergeant Basilone and his machine gunners were vastly outnumbered and without available reinforcements, Sergeant Basilone and his fellow Marines fought valiantly to check the savage and determined assault by the Japanese Imperial Army;

Whereas, for this action, Sergeant Basilone was awarded the Congressional Medal of Honor and sent home a hero;

Whereas, in December 1944, Sergeant Basilone's restlessness to rejoin his fellow Marines, who were fighting the bloody island-to-island battles en route to the Philippines and Japan, prompted him to volunteer again for combat;

Whereas, on Iwo Jima, on February 19, 1945, Sergeant Basilone again distinguished himself by single-handedly destroying an enemy blockhouse while braving heavy-caliber fire;

Whereas, minutes later, an artillery shell killed Sergeant Basilone and 4 of his platoon members;

Whereas Sergeant Basilone was posthumously awarded the Navy Cross and Purple Heart, and a life-sized bronze statue stands in Raritan, New Jersey, where ''Manila John'' is clad in battle dress and cradles a machine gun in his arms;

Whereas, in 1949, the United States Government commissioned a destroyer the U.S.S. Basilone, and in November 1951, Governor Alfred E. Driscoll posthumously awarded Sergeant Basilone the State of New Jersey's highest decoration;

Whereas, following World War II, Sergeant Basilone's remains were reinterred in the Arlington National Cemetery;

Whereas Sergeant Basilone was the first recipient of the Congressional Medal of Honor awarded in World War II;

Whereas Sergeant Basilone was also awarded the Navy Cross and the Purple Heart, giving him the distinction of being the only enlisted Marine in World War II to receive all 3 medals; and

Whereas commemorative postage stamps have been commissioned to honor other great heroes in American history: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that—

(1) a commemorative postage stamp should be issued by the United States Postal Service honoring Gunnery Sergeant John Basilone; and

(2) the Citizens' Stamp Advisory Committee should recommend to the Postmaster General that such a stamp be issued.

Mr. CORZINE. Mr. President, I rise today to submit a concurrent resolution calling on the United States Postal Service to issue a commemorative postage stamp honoring an extraordinary American hero: Gunnery Sergeant John Basilone. Basilone is the only person in American history to be awarded both the Congressional Medal of Honor and the Navy Cross. Only one USPS stamp has ever commemorated an individual Marine, a stamp featuring John Phillip Sousa; it bears noting that although Sousa was a Marine, he was not selected for his service on the battlefield. It is time to remember the tremendous sacrifice of at least one individual Marine, John Basilone, an American Patriot.

John Basilone was raised in Raritan, NJ, one of ten children in a large Italian-American family. Soon after he turned 18, Basilone heeded the patriotic call and enlisted in the U.S. Army. Basilone was immediately sent to the Philippines where he earned a nickname that would stick with him for the rest of his career: ''Manila John.''

Following his tour of duty in 1937, Basilone returned to Raritan. But he wouldn't stay there long. In July 1940—with much of Europe at war and the United States on the brink—''Manila John'' left New Jersey, enlisting in the military once again, this time joining the United States Marine Corps.

On October 24, 1942, Basilone earned his Congressional Medal of Honor. He was sent to a position on the Tenaru River at Guadalcanal and placed in command of two sections of heavy machine guns. Sergeant Basilone and his men were charged with defending Henderson Airfield, an important American foothold on the island. Although the Marine contingent was vastly outnumbered and without needed support,

Basilone and his men successfully repelled a Japanese assault. Other survivors reported that their success can be attributed to one man: ''Manila John.'' He crossed enemy lines to replenish a dangerously low stockpile of ammunition, repaired artillery pieces, and steadied his troops in the midst of torrential rain. He went several days and nights without food or sleep, and the U.S. military was able to carry the day. His exploits became Marine lore, and served as a patriotic inspiration to others facing daunting challenges in the midst of war.

For his courage under fire and profound patriotism, Basilone was the first enlisted Marine to be awarded the Congressional Medal of Honor. When he returned to the United States, he was heralded as a hero and quickly sent on tour around the country to help finance the war through the sale of war bonds. The Marine Corps offered to commission Basilone as an officer and station him far away from the frontlines.

But Basilone was not interested in riding out the war in Washington, DC. He was quoted as saying, ''I ain't no officer, and I ain't no museum piece. I belong back with my outfit.'' In December 1944, he got his wish and returned to the frontlines.

General Douglas MacArthur called him ''a one-man army,'' and on February 19, 1945 at Iwo Jima, Basilone once again lived up to that reputation. Basilone destroyed an enemy stronghold, a blockhouse on that small Japanese island and commanded his young troops to move the heavy guns off the beach. Unfortunately, less than two hours into the assault on that fateful day in February, Basilone and four of his fellow Marines were killed when an enemy mortar shell exploded nearby.

When Gunnery Sergeant John Basilone died he was only 27, but he had already earned the Congressional Medal of Honor, the Navy Cross, the Purple Heart, and the appreciation of his Nation. Basilone is a true American patriot whose legacy should be preserved.

Now more than ever, the United States needs to honor and praise the courageous efforts put forth by the men and women of our military. I strongly urge my colleagues to support this resolution as an important message to our soldiers that we appreciate and admire all of their efforts in the war on terrorism.

SENATE CONCURRENT RESOLUTION 57—HONORING DR. NORMAN CHRISTOPHER FRANCIS, PRESIDENT OF XAVIER UNIVERSITY OF LOUISIANA, FOR HIS LONG-STANDING DEDICATION AND SERVICE SPECIFIC TO XAVIER UNIVERSITY AND TO EDUCATION AS A WHOLE

Ms. LANDRIEU submitted the following concurrent resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. CON. RES. 57

Whereas Dr. Norman C. Francis, an educator and institution builder, earned a Bachelor of Science degree from Xavier University of Louisiana, received a Juris Doctorate degree from Loyola University of the South Law School, and served in the Third Armored Division of the United States Army;

Whereas Dr. Norman C. Francis has served as president of Xavier University of Louisiana for 34 years, which ranks him among the most tenured of college presidents now serving in the United States;

Whereas Dr. Norman C. Francis embodies a spirit of greatness and leadership in his roles as an outstanding president and advocate for academic excellence at Xavier University;

Whereas Dr. Norman C. Francis has created an environment at Xavier University that gives students the opportunity to gain valuable knowledge and skills that are necessary for success in today's challenging world; and

Whereas Dr. Norman C. Francis has diligently served the African-American and other minority communities: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring),

SECTION 1. COMMENDATION.

That Congress—

(1) is grateful to Dr. Norman Christopher Francis;

(2) honors Dr. Francis for his steadfast commitment and dedication to education;

(3) commends Dr. Francis for recognizing the need for diversity in education; and

(4) hopes that Dr. Norman C. Francis, an educator and institution builder, continues to be a leader of the best and brightest students and educators.

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to Dr. Norman Christopher Francis.

Ms. LANDRIEU. Mr. President, I rise to make a few remarks concerning an individual who has longstanding dedication and service specific to Xavier University and to education as a whole. Dr. Francis is being honored by the Urban League of Greater New Orleans on June 28, 2003, for his leadership at Xavier University as an outstanding President and advocate for academic excellence.

Mr. President, I wish to recognize Dr. Norman C. Francis who has exhibited a spirit of greatness and for his leadership at Xavier University of Louisiana as an outstanding President and advocate for academic excellence.

It is certainly important to reflect upon his accomplishments as Dr. Francis is still motivated to new levels, to enhance educational opportunities throughout our colleges and universities and throughout the community at large.

AMENDMENTS SUBMITTED & PROPOSED

SA 1094. Mr. SESSIONS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table.

SA 1095. Mr. REID (for Mr. JOHNSON (for himself and Mr . COCHRAN)) proposed an amendment to the bill S. 1, supra.

SA 1096. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra.

SA 1097. Mr. McCONNELL proposed an amendment to the bill S. 1, supra.

SA 1098. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1099. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1100. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1101. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1102. Mr. McCONNELL proposed an amendment to the bill S. 1, supra.

SA 1103. Mr. DORGAN (for himself and Mr. PRYOR) proposed an amendment to amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, supra.

SA 1104. Mr. KOHL (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1105. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1106. Mr. HATCH (for himself and Mr. WYDEN) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1107. Mr. COCHRAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1108. Mr. DURBIN proposed an amendment to the bill S. 1, supra.

SA 1109. Mr. BURNS (for himself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1110. Mr. BAUCUS (for Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1111. Mr. BAUCUS (for Mr. LEVIN (for himself, Ms. STABENOW, and Mrs. CLINTON)) proposed an amendment to the bill S. 1, supra.

SA 1112. Mr. KERRY submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1113. Mr. GRASSLEY proposed an amendment to the bill S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

SA 1114. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

SA 1115. Mr. KYL (for himself, Mr. HATCH, and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1116. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr . SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1117. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1118. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr . SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1121. Mr. KYL (for himself, Mr. NICKLES, Mr. GREGG, Mr. THOMAS, and Mr. LOTT) proposed an amendment to the bill S. 1, supra.

SA 1122. Mr. BROWNBACK (for himself and Mr. NELSON, of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1123. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1124. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1125. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1126. Mrs. DOLE (for herself and Mr. EDWARDS) submitted an amendment intended to be proposed by her to the bill S. 1, supra.

SA 1127. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1128. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1129. Mr. DASCHLE (for Mr. KERRY) submitted an amendment intended to be proposed by Mr. Daschle to the bill S. 1 , supra; which was ordered to lie on the table.

SA 1130. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1131. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1132. Mr. SANTORUM proposed an amendment to the bill S. 1 , supra.

SA 1133. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, supra.

TEXT OF AMENDMENTS

SA 1094. Mr. SESSIONS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 637, line 1, strike ''no debt'' and all that follows through line 5, and insert the following: ''the sponsor of such an alien shall be responsible for paying 100 percent of the costs attributable to the provision of such assistance, unless the sponsor demonstrates that the sponsor has an extreme and unusual financial hardship that prevents the sponsor from paying such costs.''

SA 1095. Mr. REID (for himself and Mr. COCHRAN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. ___. MEDICATION THERAPY MANAGEMENT ASSESSMENT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 geographic areas, each containing not less than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(3) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the program not later than January 1, 2005, but may not implement the assessment program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as an assessment site under subsection (a)(2) may participate in the assessment program under this section if such beneficiary identifies a qualified pharmacist who agrees to furnish medication therapy management services to the eligible beneficiary under the assessment program.

(c) CONTRACTS WITH QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF QUALIFIED PHARMACISTS.—The Secretary may contract with more than 1 qualified pharmacist at each site.

(d) PAYMENT TO QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—Under an contract entered into under subsection (c), the Secretary shall pay qualified pharmacists a fee for providing medication therapy management services.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The Secretary shall, in consultation with national pharmacist and pharmacy associations, design the fee paid under paragraph (1) to test various payment methodologies applicable with respect to medication therapy management services, including a payment methodology that applies a relative value scale and fee-schedule with respect to such services that take into account the differences in—

(A) the time required to perform the different types of medication therapy management services;

(B) the level of risk associated with the use of particular outpatient prescription drugs or groups of drugs; and

(C) the health status of individuals to whom such services are provided.

(e) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the assessment program under this section.

(2) BUDGET NEUTRALITY.—In conducting the assessment program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the assessment program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the assessment program under this section.

(g) AVAILABILITY OF DATA.—During the period in which the assessment program is conducted, the Secretary annually shall make available data regarding—

(1) the geographic areas and sites designated under subsection (a)(2);

(2) the number of eligible beneficiaries participating in the program under subsection (b) and the level and types medication therapy management services used by such beneficiaries;

(3) the number of qualified pharmacists with contracts under subsection (c), the location of such pharmacists, and the number of eligible beneficiaries served by such pharmacists; and

(4) the types of payment methodologies being tested under subsection (d)(2).

(h) REPORT.—

(1) IN GENERAL.—Not later than 6 months after the completion of the assessment program under this section, the Secretary shall submit to Congress a final report summarizing the final outcome of the program and evaluating the results of the program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The final report submitted under paragraph (1) shall include an assessment of the feasibility and appropriateness of the various payment methodologies tested under subsection (d)(2).

(i) DEFINITIONS.—In this section:

(1) MEDICATION THERAPY MANAGEMENT SERVICES.—The term ''medication therapy management services'' means services or programs furnished by a qualified pharmacist to an eligible beneficiary, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual's understanding of the appropriate use of medications;

(C) to increase the individual's compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications; and

(E) to reduce the need for other costly medical services through better management of medication therapy.

(2) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) receiving, in accordance with State law or regulation, medication for—

(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or

(ii) such other chronic diseases as the Secretary may specify.

(3) QUALIFIED PHARMACIST.—The term ''qualified pharmacist'' means an individual who is a licensed pharmacist in good standing with the State Board of Pharmacy.

SA 1096. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend the title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms ''hospital'' and ''critical access hospital'' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SA 1097. Mr. MCCONNELL proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medical program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. ___. PROTECTING SENIORS WITH CANCER.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cancer shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with cancer, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with cancer, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cancer, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

SA 1098. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

''(B) ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the transportation originates in a rural area described in subparagraph (C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by the higher of either 20 percent of the rate determined after the application of subparagraph (C), in addition to the increase provided under subparagraph (A).

''(C) DETERMINATION OF RURAL AREAS BASED ON POPULATION DENSITY WITHIN POSTAL ZIP CODES.—With respect to ground ambulance services described in subparagraph (B), during the period described in that subparagraph, paragraph (9) shall be applied by substituting '(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)' for '(as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725))'. Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 221(b)(3) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and shall establish the classification system required by the application of this subparagraph. The Secretary shall provide such increased payment for services furnished on or after the earlier of 30 days after the establishment of such classification system or December 31, 2003.

''(D) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

''(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.''.

SEC. 426A. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1099. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) of the Social Security Act (42 U.S.C. §1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs.

''(10) TEMPORARY INCREASE FOR AMBULANCE SERVICES.—

''(A) GROUND AMBULANCE SERVICES.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004 and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established shall be increased by 21.5 percent.

''(B) ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004 and before January 1, 2007, for which the transportation originates in a rural area described in paragraph (10)(C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established shall be increased by the higher of either 20 percent or the following section:

''(C) BASING RURAL AREAS ON POPULATION DENSITY BY POSTAL ZIP CODES.''

(a) IN GENERAL.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) is amended in paragraph (9), as so redesignated by section 2(a)(1), by striking ''(as defined in section 1886(d)(2)(D)'' and all that follows through ''(57 Fed. Reg. 6725)'' and inserting ''(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)''.

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services, taking into account the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall implement such increase in addition to the increase under subparagraph (A). The Secretary shall establish the classification system described in the amendment made by subsection (a) by not later than December 31, 2003. Such amendment shall apply to services furnished on or after such date, not later than 30 days after the establishment of such system, as the Secretary shall provide by regulation.

''(D) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.''

''(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.''

SA 1100. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title I, add the following:

SEC. ___. INCREASE IN DRUG BENEFIT.

Notwithstanding any other provision of law, the Secretary shall use $12,000,000,000 to improve the prescription drug benefit added under part D of title XVIII of the Social Security Act (as added by section 101) by eliminating coverage gaps, reducing the premium or cost-sharing, or expanding subsidies for low-income beneficiaries in lieu of conducting any demonstration projects or making any increased payments to providers authorized under this Act or the amendments made by this Act.

SA 1101. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; which was ordered to lie on the table; as follows:

On page 134, strike line 9 and insert the following:

under paragraph (1).

''(d) IMPLEMENTATION OF PART D.—

''(1) IN GENERAL.—Notwithstanding section 1860D–1(a)(4) or any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part on January 1, 2005, unless the Secretary certifies in writing to Congress, by not later than March 1, 2004, that such implementation is not possible. If such implementation is possible by January 1, 2005, the Secretary shall carry out this part until the Administrator is appointed and able to carry out this part. The Secretary shall implement sections 1807 and 1807A until the date of implementation as certified by the Secretary.

''(2) CERTIFICATION REQUIREMENTS.—A certification by the Secretary under paragraph (1) that implementation of this part is not possible by January 1, 2005, shall declare the reasons for the impossibility and a new date certain (which in no event shall be later than January 1, 2006) for implementation of this part.

SA 1102. Mr. MCCONNELL proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. ___. PROTECTING SENIORS WITH ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph

(1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

SA 1103. Mr. DORGAN (for himself and Mr. PRYOR) proposed an amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; as follows:

In lieu of the matter proposed to be inserted, insert the following:

SEC. ___. AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:

''(d) AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall for each year (beginning with 2009) determine a percentage which—

''(1) shall apply in lieu of the applicable percent otherwise determined under subsection (c) for that year, and

''(2) will result in a decrease of $2,400,000,000 for that year in the aggregate monthly beneficiary obligations otherwise required of all eligible beneficiaries enrolled in a Medicare Prescription Drug Plan or a Medicare Advantage plan that provides qualified prescription drug coverage.5

This subsection shall not apply in determining the applicable percent under subsection (c) for purposes of section 1860D–21.''.

SA 1104. Mr. KOHL (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. 6___. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—

(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

(A) MEDICARE PROGRAM.—Section 1819(b)(42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:

''(8) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

''(A) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

''(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

''(ii) require, as a condition of employment, that such worker—

''(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

''(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

''(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

''(IV) provide any other identification information the Secretary may specify in regulation;

''(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

''(iv) if that system does not contain any such disqualifying information—

''(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(6); and

''(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

''(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

''(i) IN GENERAL.—A skilled nursing facility may not knowingly employ any skilled nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

''(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a skilled nursing facility may provide for a provisional period of employment for a skilled nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the covered individual during the worker's provisional period of employment.

''(iii) EXCEPTION FOR SMALL RURAL SKILLED NURSING FACILITIES.—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of skilled nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

''(C) REPORTING REQUIREMENTS.—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

''(D) USE OF INFORMATION.—

''(i) IN GENERAL.—A skilled nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

''(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility that, in denying employment for an individual selected for hiring as a skilled nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

''(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

''(E) CIVIL PENALTY.—

''(i) IN GENERAL.—A skilled nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

''(I) for the first such violation, $2,000; and

''(II) for the second and each subsequent violation within any 5-year period, $5,000.

''(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a skilled nursing facility that—

''(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

''(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

''(F) DEFINITIONS.—In this paragraph:

''(i) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

''(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

''(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

''(ii) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

''(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding

by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

''(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

''(II) such other types of acts as the Secretary may specify in regulations.

''(iv) SKILLED NURSING FACILITY WORKER.—The term 'skilled nursing facility worker' means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.''.

(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396r(b)) is amended by adding at the end the following new paragraph:

''(8) SCREENING OF NURSING FACILITY WORKERS.—

''(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a nursing facility selects an individual for a position as a nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

''(i) give the worker written notice that the facility is required to perform background checks with respect to provisional employees;

''(ii) require, as a condition of employment, that such worker—

''(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

''(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

''(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

''(IV) provide any other identification information the Secretary may specify in regulation;

''(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

''(iv) if that system does not contain any such disqualifying information—

''(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(8); and

''(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

''(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

''(i) IN GENERAL.—A nursing facility may not knowingly employ any nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

''(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a nursing facility may provide for a provisional period of employment for a nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the worker during the worker's provisional period of employment.

''(iii) EXCEPTION FOR SMALL RURAL NURSING FACILITIES.—

''(I) IN GENERAL.—In the case of a small rural nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

''(C) REPORTING REQUIREMENTS.—A nursing facility shall report to the State any instance in which the facility determines that a nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

''(D) USE OF INFORMATION.—

''(i) IN GENERAL.—A nursing facility that obtains information about a nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

''(ii) IMMUNITY FROM LIABILITY.—A nursing facility that, in denying employment for an individual selected for hiring as a nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

''(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

''(E) CIVIL PENALTY.—

''(i) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

''(I) for the first such violation, $2,000; and

''(II) for the second and each subsequent violation within any 5-year period, $5,000.

''(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that—

''(I) knowingly continues to employ a nursing facility worker in violation of subparagraph (A) or (B); or

''(II) knowingly fails to report a nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

''(F) DEFINITIONS.—In this paragraph:

''(i) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

''(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

''(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

''(ii) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

''(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a nursing facility worker has committed—

''(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

''(II) such other types of acts as the Secretary may specify in regulations.

''(iv) NURSING FACILITY WORKER.—The term 'nursing facility worker' means any individual (other than a volunteer) that has access to a patient of a nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.''.

(2) FEDERAL RESPONSIBILITIES.—

(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisional employee at a nursing facility may complete and Federal and State agencies may use to conduct the criminal background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate response to long-term care providers using the system.

(3) NO PREEMPTION OF STRICTER STATE LAWS.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8), 1396r(b)(8)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1128E(g)(6) of the Social Security Act (as added by subsection (e)) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as so defined) to conduct a background check prior to employing an individual in an employment position that is not included in the positions for which a background check is required under such sections.

(4) TECHNICAL AMENDMENTS.—Effective as if included in the enactment of section 941 of BIPA (114 Stat. 2763A–585), sections 1819(b) and 1919(b) (42 U.S.C. 1395i–3(b), 1396r(b)), as amended by such section 941 are each amended by redesignating the paragraph (8) added by such section as paragraph (9).

(b) FEDERAL AND STATE REQUIREMENTS CONCERNING BACKGROUND CHECKS.—

(1) MEDICARE.—Section 1819(e) (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following:

''(6) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

''(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

''(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

''(C) STATE REPORTING OF INFORMATION TO SKILLED NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

''(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

''(ii) immediately report to the skilled nursing facility in writing the results of such review; and

''(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

''(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

''(i) AUTHORITY TO CHARGE FEES.—

''(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation until expended.

''(II) STATE.—A State may charge a skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

''(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

''(E) REGULATIONS.—

''(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(9), including regulations regarding the security confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

''(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

''(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

''(i) the number of requests for searches and exchanges of records made under this section;

''(ii) the disposition of such requests; and

''(iii) the cost of responding to such requests.''.

(2) MEDICAID.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

''(8) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

''(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

''(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

''(C) STATE REPORTING OF INFORMATION TO NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

''(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

''(ii) immediately report to the nursing facility in writing the results of such review; and

''(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

''(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

''(i) AUTHORITY TO CHARGE FEES.—

''(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation, until expended.

''(II) STATE.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

''(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

''(E) REGULATIONS.—

''(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

''(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

''(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

''(i) the number of requests for searches and exchanges of records made under this section;

''(ii) the disposition of such requests; and

''(iii) the cost of responding to such requests.''.

(c) APPLICATION TO OTHER ENTITIES PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES.—

(1) MEDICARE.—Part D of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

''APPLICATION OF SKILLED NURSING FACILITY PREVENTIVE ABUSE PROVISIONS TO ANY PROVIDER OF SERVICES OR OTHER ENTITY PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES

''SEC. 1897. (a) IN GENERAL.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a 'medicare beneficiary').

''(b) SUPERVISION OF PROVISIONAL EMPLOYEES.—

''(1) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1819(b)(8)(B)(ii) or

1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

''(2) REQUIREMENTS.—The regulations required under paragraph (1) shall provide the following:

''(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a medicare beneficiary.

''(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

''(i) Follow-up telephone calls to the medicare beneficiary.

''(ii) Unannounced visits to the medicare beneficiary's home while the provisional employee is serving the medicare beneficiary.

''(iii) To the extent practicable, limiting the provisional employee's duties to serving only those medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the medicare beneficiary is present.

''(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such regulations should encourage the provision of monitoring and oversight activities whenever practicable with respect to such an entity, and if such activities would not impose an unreasonable cost or other burden on the entity.''.

(2) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a), as amended by section 104(a), is amended—

(A) in paragraph (65), by striking ''and'' at the end;

(B) in paragraph (66), by striking the period and inserting ''; and''; and

(C) by inserting after paragraph (66) the following:

''(67) provide that any entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services for which medical assistance is available under the State plan to individuals requiring long-term care complies with the requirements of subsections (b)(8) and (e)(8) of section 1919 and section 1897(b) (in the same manner as such section applies to a medicare beneficiary).''.

(3) EXPANSION OF STATE NURSE AIDE REGISTRY.—

(A) MEDICARE.—Section 1819 (42 U.S.C. 1395i–3) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking ''NURSE AIDE REGISTRY'' and inserting ''EMPLOYEE REGISTRY'';

(II) in subparagraph (A)—

(aa) by striking ''By not later than January 1, 1989, the'' and inserting ''The'';

(bb) by striking ''a registry of all individuals'' and inserting ''a registry of (i) all individuals''; and

(cc) by inserting before the period the following: '', (ii) all other skilled nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property''; and

(III) in subparagraph (C), by striking ''a nurse aide'' and inserting ''an individual''; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: ''The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a skilled nursing facility employee of a resident in a skilled nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii).''; and

(II) in the fourth sentence of subparagraph (C), by inserting ''or described in subsection (e)(2)(A)(iii)'' after ''used by the facility''; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking ''NURSE AIDE''; and

(bb) in clause (i), in the matter preceding subclause (I), by striking ''a nurse aide'' and inserting ''an individual''; and

(cc) in clause (i)(I), by striking ''nurse aide'' and inserting ''individual''.

(B) MEDICAID.—Section 1919 (42 U.S.C. 1396r) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking ''NURSE AIDE REGISTRY'' and inserting ''EMPLOYEE REGISTRY'';

(II) in subparagraph (A)—

(aa) by striking ''By not later than January 1, 1989, the'' and inserting ''The'';

(bb) by striking ''a registry of all individuals'' and inserting ''a registry of (i) all individuals''; and

(cc) by inserting before the period the following: '', (ii) all other nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of an entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property''; and

(III) in subparagraph (C), by striking ''a nurse aide'' and inserting ''an individual''; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: ''The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility employee of a resident in a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii).''; and

(II) in the fourth sentence of subparagraph (C), by inserting ''or described in subsection (e)(2)(A)(iii)'' after ''used by the facility''; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking ''NURSE AIDE''; and

(bb) in clause (i), in the matter preceding subclause (I), by striking ''a nurse aide'' and inserting ''an individual''; and

(cc) in clause (i)(I), by striking ''nurse aide'' and inserting ''individual''.

(d) REIMBURSEMENT OF COSTS FOR BACKGROUND CHECKS.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1819(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1395i–3(b)(8), 1396r(b)(8)), as added by this section.

(e) INCLUSION OF ABUSIVE ACTS WITHIN A LONG-TERM CARE FACILITY OR PROVIDER IN THE NATIONAL HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.—

(1) IN GENERAL.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a–7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

''(v) A finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient's or resident's property.''.

(2) COVERAGE OF LONG-TERM CARE FACILITY OR PROVIDER EMPLOYEES.—Section 1128E(g)(2) (42 U.S.C. 1320a–7e(g)(2)) is amended by inserting '', and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, providing services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)'' before the period.

(3) REPORTING BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

(A) IN GENERAL.—Section 1128E(b)(1) (42 U.S.C. 1320a–7e(b)(1)) is amended by striking ''and health plan'' and inserting '', health plan, and long-term care facility or provider''.

(B) CORRECTION OF INFORMATION.—Section 1128E(c)(2) (42 U.S.C. 1320a–7e(c)(2)) is amended by striking ''and health plan'' and inserting '', health plan, and long-term care facility or provider''.

(4) ACCESS TO REPORTED INFORMATION.—Section 1128E(d)(1) (42 U.S.C. 1320a–7e(d)(1)) is amended by striking ''and health plans'' and inserting '', health plans, and long-term care facilities or providers''.

(5) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—Section 1128E(d) (42 U.S.C. 1320a–7e(d)) is amended by adding at the end the following:

''(3) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—A long-term care facility or provider shall check the database maintained under this section prior to hiring under an employment or other contract, or both, (other than in a provisional status) any individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, that will provide services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants).''.

(6) DEFINITION OF LONG-TERM CARE FACILITY OR PROVIDER.—Section 1128E(g) (42 U.S.C. 1320a–7e(g)) is amended by adding at the end the following:

''(6) LONG-TERM CARE FACILITY OR PROVIDER.—The term 'long-term care facility or provider' means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(dd)(1)), a long-term care hospital (as described in section 1886(d)(1)(B)(iv)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, home health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program under title XVIII or the medicaid program under title XIX.''.

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the amendments made by this subsection, $10,200,000 for fiscal year 2004.

(f) PREVENTION AND TRAINING DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall be a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to—

(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsman programs, the long-term care industry, and local community members;

(B) examine patient care issues relating to regulatory oversight, community involvement, and facility staffing and management with a focus on staff training, staff stress management, and staff supervision;

(C) examine the use of patient abuse prevention training programs by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used; and

(D) identify and disseminate best practices for preventing and reducing patient abuse.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—With respect to a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) or a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 6 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2006.

(2) LONG-TERM CARE FACILITIES AND PROVIDERS.—With respect to a long-term care facility or provider (as defined in section 1128E(g)(6) of the Social Security Act (42 U.S.C. 1320a–7e(g)(6)) (as added by subsection (e)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 18 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2007.

SA 1105. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 486, line 3, insert ''and'' after the semicolon at the end.

On page 486, line 4, insert ''(I)'' after ''(ii)''.

On page 486, line 8, strike ''and'' and insert ''or''.

On page 486, line 9, strike ''(iii)'' and insert ''(II)''.

SA 1106. Mr. HATCH (for himself and Mr. WYDEN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, insert the following:

SEC. ___. HEALTH CARE THAT WORKS FOR ALL AMERICANS-CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this Act are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens' Health Care Working Group (referred to in this Act as the ''Working Group'').

(d) APPOINTMENT.—Not later than 45 days after the date of enactment of this Act, the Speaker and Minority Leader of the House of Representatives and the Majority Leader and Minority Leader of the Senate (in this section referred to as the ''leadership'') shall each appoint individuals to serve as members of the Working Group in accordance with subsections (e), (f), and (g).

(e) MEMBERSHIP CRITERIA.—

(1) APPOINTED MEMBERS.—

(A) SEPARATE APPOINTMENTS.—The Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate, shall each appoint 1 member of the Working Group described in subparagraphs (A), (G), (J), (K), and (M) of paragraph (2).

(B) JOINT APPOINTMENTS.—Members of the Working Group described in subparagraphs (B), (C), (D), (E), (F), (I), and (N) of paragraph (2) shall be appointed jointly by the leadership.

(C) COMBINED APPOINTMENTS.—Members of the Working Group described in subparagraphs (H) and (L) shall be appointed in the following manner:

(i) One member of the Working Group in each of such subparagraphs shall be appointed jointly by the leadership.

(ii) The remaining appointments of the members in each of such subparagraphs shall be divided equally such that the Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate each appoint an equal number of members.

(2) CATEGORIES OF APPOINTED MEMBERS.—Members of the Working Group shall be appointed as follows:

(A) 2 members shall be patients or family members of patients who, at least 1 year prior to the date of enactment of this Act, have had no health insurance.

(B) 1 member shall be a representative of children.

(C) 1 member shall be a representative of the mentally ill.

(D) 1 member shall be a representative of the disabled.

(E) 1 member shall be over the age of 65 and a beneficiary under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(F) 1 member shall be a recipient of benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(G) 2 members shall be State health officials.

(H) 3 members shall be employers, including—

(i) 1 large employer (an employer who employed 50 or more employees on business days during the preceding calendar year and who employed at least 50 employees on the first of the year);

(ii) 1 small employer (an employer who employed an average of at least 2 employees but less than 50 employees on business days in the preceding calendar year and who employs at least 2 employees on the first of the year); and

(iii) 1 multi-state employer.

(I) 1 member shall be a representative of labor.

(J) 2 members shall be health insurance issuers.

(K) 2 members shall be health care providers.

(L) 5 members shall be appointed as follows:

(i) 1 economist.

(ii) 1 academician.

(iii) 1 health policy researcher.

(iv) 1 individual with expertise in pharmacoeconomics.

(v) 1 health technology expert.

(M) 2 members shall be representatives of community leaders who have developed State or local community solutions to the problems addressed by the Working Group.

(N) 1 member shall be a representative of a medical school.

(3) SECRETARY.—The Secretary, or the designee of the Secretary, shall be a member of the Working Group.

(f) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include members of Congress or other elected government officials (Federal, State, or local) other than those individuals specified in subsection (e). To the extent possible, individuals appointed to the Working Group shall have used the health care system within the previous 2 years and shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(g) APPOINTMENT CRITERIA.—

(1) HOUSE OF REPRESENTATIVES.—The Speaker and Minority Leader of the House of Representatives shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the House of Representatives:

(A) The Committee on Ways and Means.

(B) The Committee on Energy and Commerce.

(C) The Committee on Education and the Workforce.

(2) SENATE.—The Majority Leader and Minority Leader of the Senate shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the Senate:

(A) The Committee on Finance.

(B) The Committee on Health, Education, Labor, and Pensions.

(h) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a term of 2 years. Such term is renewable and any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(i) APPOINTMENT OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d), the leadership shall make a joint designation of the chairperson of the Working Group. If the leadership fails to make such designation within such time period, the Working Group Members shall, not later than 10 days after the end of such time period, designate a chairperson by majority vote.

(j) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(k) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of appointment of the chairperson under subsection (i), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this Act. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, ''The Health Report to the American People''. Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Working Group shall initiate health care community meetings throughout the United States (in this section referred to as ''community meetings''). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) MEETING REQUIREMENTS.—

(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) TOPICS.—The community meetings shall, at a minimum, address the following issues:

(I) The optimum way to balance costs and benefits so that affordable health coverage is available to as many people as possible.

(II) The identification of services that provide cost-effective, essential health care services to maintain and improve health and which should be included in health care coverage.

(III) The cost of providing increased benefits.

(IV) The mechanisms to finance health care coverage, including defining the appropriate financial role for individuals, businesses, and government.

(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(l) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (k)(4)(D), the Working Group shall submit to Congress and the President a final set of recommendations.

(m) ADMINISTRATION.—

(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this Act. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) POSTAL SERVICES.—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(n) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(o) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(p) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(q) SUNSET OF WORKING GROUP.—The Working Group shall terminate when the report described in subsection (l) is submitted to Congress.

(r) ADMINISTRATION REVIEW AND COMMENTS.—Not later than 45 days after receiving the final recommendations of the Working Group under subsection (l), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for such legislation and administrative actions as the President considers appropriate.

(s) REQUIRED CONGRESSIONAL ACTION.—Not later than 45 days after receiving the report submitted by the President under subsection (r), each committee of jurisdiction of Congress shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (l).

(t) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this Act, other than subsection (k)(3), $3,000,000 for each of fiscal years 2004, 2005, and 2006.

(2) HEALTH REPORT TO THE AMERICAN PEOPLE.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (k)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SA 1107. Mr. COCHRAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. ___. AUTHORIZATION OF APPROPRIATIONS TO CONTINUE THE EXISTING CMS MEDICATION MONITORING SYSTEM.

There are authorized to be appropriated such sums as are necessary to continue the Prescription Continuity of Care medication monitoring system in cooperation with the CMS Mississippi Quality Improvement Organization, Information Healthcare, and the University of Mississippi.

SA 1108. Mr. DURBIN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. ___. ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES UNDER PART D.

Section 1860D–26, as added by section 101, is amended by adding at the end the following:

''(d) ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES.—

''(1) PROGRAM.—Subject to paragraph (2), the Administrator shall implement a program (for the period beginning on January 1, 2009, and ending on September 30, 2013) to provide additional assistance to applicable eligible beneficiaries who have reached the initial coverage limit described in section 1860D–6(c)(3) for the year but have not reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)) for the year in order to reduce the cost-sharing requirement during this coverage gap.

''(2) FUNDING LIMITATION.—The Administrator shall implement the program described in paragraph (1) in such a manner that will result in a decrease of $12,000,000,000 in cost-sharing for covered drugs under part D by applicable eligible beneficiaries during the period described in such paragraph. The Administrator shall take appropriate steps to ensure that the costs of the program during such period do not exceed $12,000,000,000.

''(3) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'applicable eligible beneficiary' means an eligible beneficiary with cardiovascular disease, diabetes and its complications, cancer, or Alzheimer's disease who is enrolled under part D.''.

SA 1109. Mr. BURNS (for himself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on table; as follows:

On page 68, between lines 5 and 6, insert the following:

''(E) Not be less than 1,000,000 eligible beneficiaries shall reside in each service area.

On page 354, between lines 19 and 20, insert the following:

''(F) Not be less than 1,000,000 MedicareAdvantage eligible individuals shall reside in each region.

SA 1110. Mr. BAUCUS (for Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan or entering private insurance under this act.

SA 1111. Mr. BAUCUS (for Mr. LEVIN (for himself, Ms. STABENOW, and Mrs. CLINTON)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that the 37% of current retirees who have prescription drug coverage, estimated by the Congressional Budget Office who will lose their current employer retiree coverage as a result of the enactment of this legislation will have the option to enter either a Medicare backup plan or private insurance under this act.

SA 1112. Mr. KERRY submitted an amendment intended to by proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

After section 404, insert the following:

SEC. 404A. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) DISPROPORTIONATE SHARE ADJUSTMENT PERCENTAGE.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking ''35 percent'' and inserting ''35 percent (or, for discharges occurring on or after October 1, 2003, 40 percent)''.

(b) CAPITAL COSTS.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv), by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following new clause:

''(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).''.

SA 1113. Mr. GRASSLEY proposed an amendment to the bill S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Programs; as follows:

At the end, add the following:

SEC. 2. TECHNICAL CORRECTION.

(a) TEMPORARY INCREASE OF THE MEDICAID FMAP.—Section 401(a)(6)(A) of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027) is amended by inserting ''after September 2, 2003,'' after ''(42 U.S.C. 1315))''.

(b) RETROACTIVE EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 401 of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027).

SA 1114. Mr. KYL submitted an amendment intended to be proposed by

him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G–7 COUNTRIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance;

(2) The proportion of the cost for innovation borne by American consumers compared with consumers in the other six countries;

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production (''Ramsey prices'');

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health;

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States;

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied;

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant; and

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violation of intellectual property rights for prescription medicines.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the Untied States shall submit to Congress a report on the study conducted under subsection (A).

SA 1115. Mr. KYL (for himself, Mr. HATCH, and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without Congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2% in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4% cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991–2003, payment rates for physicians and health professionals fell 14% behind practice cost inflation as measured by Medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

SA 1116. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

''(B) ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the transportation originates in a rural area described in subparagraph (C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by the higher of either 20 percent of the rate determined after the application of subparagraph (C), in addition to the increase provided under subparagraph (A).

''(C) DETERMINATION OF RURAL AREAS BASED ON POPULATION DENSITY WITHIN POSTAL ZIP CODES.—With respect to ground ambulance services described in subparagraph (B), during the period described in that subparagraph, paragraph (9) shall be applied by substituting '(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)' for '(as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725))'. Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 221(b)(3) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and shall establish the classification system required by the application of this subparagraph. The Secretary shall provide such increased payment for services furnished on or after the earlier of 30 days after the establishment of such classification system or December 31, 2003.

''(D) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

''(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.''.

SEC. 426A. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be

deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1117. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, add the following:

SEC. ___. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

''PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

''SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

''SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

''(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

''(1) REVIEW.—The Commission shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

''(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

''(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

''(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

''(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

''(E) supporting the development of new data systems where existing data are insufficient or inadequate;

''(F) developing criteria and indicators of impending core health care safety net failure;

''(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

''(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

''(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

''(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

''(ii) the degree to which these plans may be overburdened by adverse selection; and

''(iii) the degree to which emergency departments are used by enrollees of these plans; and

''(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

''(2) REPORTS.—

''(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

''(i) the health care needs of the uninsured; and

''(ii) the financial and infrastructure stability of the Nation's core health care safety net.

''(B) AGENDA AND ADDITIONAL REVIEWS.—

''(i) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

''(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

''(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

''(II) If the Commission deems such additional reviews and reports appropriate.

''(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(3) DEFINITIONS.—In this section:

''(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term 'appropriate committees of Congress' means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

''(B) CORE HEALTH CARE SAFETY NET.—The term 'core health care safety net' means any health care provider that—

''(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

''(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

''(C) HEALTH CARE SAFETY NET PROGRAMS.—The term 'health care safety net programs' includes the following:

''(i) MEDICAID.—The medicaid program under title XIX.

''(ii) SCHIP.—The State children's health insurance program under title XXI.

''(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

''(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(l)(2)(B)) receives funds.

''(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(l)(1)) receives funds.

''(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

''(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

''(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

''(D) VULNERABLE POPULATIONS.—The term 'vulnerable populations' includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the 'Comptroller General'), in consultation with the appropriate committees of Congress.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

''(i) four to serve a term of 1 year;

''(ii) four to serve a term of 2 years; and

''(iii) five to serve a term of 3 years.

''(B) VACANCIES.—

''(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

''(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

''(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

''(4) COMPENSATION.—

''(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

''(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

''(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

''(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

''(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—

''(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

''(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

''(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.''.

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SA 1118. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the

Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 443 and insert the following:

SEC. 443. MEDICARE COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.

(a) PART B COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V)(iii), by adding ''and'' after the semicolon at the end; and

(3) by adding at the end the following new subparagraph:

''(W) care coordination and assessment services (as defined in subsection (ww)).''.

(b) CARE COORDINATION AND ASSESSMENT SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Care Coordination and Assessment Services

''(ww)(1) The term 'care coordination and assessment services' means services that are furnished to an eligible individual (as defined in paragraph (2)) by a care coordinator (as defined in paragraph (3)) under a plan of care prescribed by such care coordinator for the purpose of care coordination and assessment, which may include any of the following services:

''(A) an initial assessment of an individual's medical condition, functional and cognitive capacity and environmental and psychological needs and an annual assessment thereafter.

''(B) Management of transitions of care across practice settings and between providers.

''(C) Coordination of, and referral for, medical and other health-related services, including—

''(i) multidisciplinary care conferences;

''(ii) coordination with other providers, including telephone consultations with physicians; and

''(iii) monitoring and management of medications, with special emphasis on clients using multiple prescriptions (including coordination with the entity managing benefits for the individual).

''(D) Patient and family care-giver education and counseling (through office visits or telephone consultation), including self-management services and risk appraisal to identify behavioral risk factors through self assessment.

''(E) Providing information about end of life care, including referral to hospice services, when appropriate, including patient and family caregiver education and counseling about hospice, and managing and facilitating transition to hospice when elected.

''(F) Referral to and coordination with community resources.

''(G) Such other services for which payment would not otherwise be made under this title as the Secretary shall determine to be appropriate including, but not limited to, activities to facilitate continuity of care and patient adherence to plans of care.

''(2) For purposes of this subsection, the term 'eligible individual' means an individual who a care coordinator annually certifies has multiple chronic conditions and meets eligibility criteria determined by the Secretary.

''(3)(A) For purposes of this subsection, the term 'care coordinator' means an individual or entity that—

''(i) is—

''(I) a physician who provides care to at least 50 eligible individuals; or

''(II) an independent nurse practitioner who provides care to at least 50 eligible individuals;

''(ii) has entered into a care coordination agreement with the Secretary; and

''(iii) has appropriate office staffing, operating under the direction of the eligible provider, which is sufficient in size and expertise to address the complex clinical care coordination needs of participating beneficiaries in the practice;

''(iv) has an ability and process to identify eligible beneficiaries;

''(v) has an ability to coordinate care for participating beneficiaries;

''(vi) has an ability to maintain and update patient records to ensure that care provided by other treating providers (including the instructions of other treating providers and any related lab results, prescription orders, and ancillary treatment services) is included in the record;

''(vii) has an ability to periodically review the medical record of participating beneficiaries to identify problems related to transitions, poly-pharmacy, and care continuity and to respond to resolve identified problems;

''(viii) is capable of referring to and coordinating with community-based supportive services;

''(ix) has an ability to communicate with participating beneficiaries or family caregivers as needed and appropriate, using telephonic and/or electronic communications; and

''(x) agrees to coordinate care for participating beneficiaries, consult with other treating providers (including but not limited to other treating physicians, other medical professionals involved in patient care, residential and inpatient facilities, and pharmacies), and community service providers;

''(xi) agrees to recognize patient treatment preferences; and

''(xii) is certified by the Secretary as meeting standards defined by the Secretary and being capable of coordinating clinical care for eligible beneficiaries.

''(B) For purposes of subparagraph (A)(ii), each care coordination agreement shall—

''(i) be entered into for a period of 1 year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in subparagraph (A);

''(ii) contain such other terms and conditions as the Secretary may require.

''(4) For purposes of this subsection, the Secretary shall send quarterly reports to each eligible provider that inform, in aggregate, on the provider's participating beneficiary caseload, using measures determined by the Secretary that are derived from existing Medicare date sources. In preparing the reports under this paragraph, the Secretary shall consider—

''(A) the average number of emergency room and nursing home visits relative to geographic norms for all eligible beneficiaries; and

''(B) the average number of unique physician visits relative to geographic norms for all eligible beneficiaries.

''(5) For purposes of this subsection, the term 'functional limitations' means each of the following:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(6) Rural health clinics and Federally qualified health centers shall be eligible sites at which care coordination and assessment services may be provided.

''(7) For purposes of this subsection, the term 'chronic condition' means an illness, functional limitation, or cognitive impairment that is expected to last at least 1 year and limits what a person can do, and requires ongoing care.

''(8) For purposes of this subsection, the Secretary shall establish eligibility criteria for the care management benefit that would target approximately 5 percent of elderly medicare fee-for-service enrollees. The eligibility criteria should identify enrollees who need care management because they have multiple chronic conditions that result in high use of Medicare services, high use of prescription medications, and high Medicare costs. Inability to manage one's own care due to cognitive impairment should be considered as an additional indicator of need for care management.

(c) PAYMENT AND ELIMINATION OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and'' before ''(U)''; and

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to assessment services described in section 1861(s)(2)(W), the amounts paid shall be 100 percent of the lesser of the actual charge for the service or the amount determined under the payment basis determined under section 1848 by the Secretary for such service and an administrative fee shall be developed for care coordination services''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to care coordination and assessment services (as defined in section 1861(ww)(1)),''.

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

''(vii) A care coordinator (as defined in section 1861(ww)(3)) that is not a physician.''.

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

''(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICARE.—In the case of a designated health service, if the designated health service is—

''(A) a care coordination and assessment service (as defined in section 1861(ww)(1)); and

''(B) provided by a care coordinator (as defined in paragraph (3) of such section).''.

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms

and establish such procedures as the Secretary determines necessary to implement the provisions of this section.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to care coordination and assessment services furnished on or after January 1, 2006, and before January 1, 2011.

At the end of subtitle B of title IV, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007 for which the transportation originates in—

''(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

''(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent

''(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.''.

SA 1121. Mr. KYL (for himself, Mr. NICKLES, Mr. GREGG, Mr. THOMAS, and Mr. LOTT) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) FINDINGS.—The Senate makes the following findings:

(1) America's seniors deserve a fiscally-strong Medicare system that fulfills its promise to them and future retirees.

(2) The impending retirement of the ''baby boom'' generation will dramatically increase the costs of providing Medicare benefits. Medicare costs will double relative to the size of the economy from 2% of GDP today to 4% in 2025 and double again to 8% of GDP in 2075. This growth will accelerate substantially when Congress adds a necessary prescription drug benefit.

(3) Medicare's current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease management programs, and a host of other advances. Reforming Medicare to create a more self-adjusting, innovative structure is essential to improve Medicare's efficiency and the quality of the medical care it provides.

(4) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of America's seniors, not the government, and would create a powerful incentive for private-sector Medicare plans to provide the best quality health care to seniors at the most affordable price.

(5) The method by which the national preferred provider organizations in the Federal Employees Health Benefits Program have been reimbursed has proven to be a reliable and successful mechanism for providing Members of Congress and federal employees with excellent health care choices.

(6) Unlike the Medicare payment system, which has had to be changed by Congress every few years, the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most.

(2) Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2006 to ensure the long and short term viability of such options for America's seniors.

(3) Develop a payment system for the Medicare Advantage preferred provider organizations similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program.

(4) Limit the addition of new unfunded obligations in the Medicare program so that the long-term solvency of this important program is not further jeopardized.

(5) Incorporate private sector, market-based elements, that do not rely on the inefficient Medicare price control structure.

(6) Keep the cost of structural changes and new benefits within the $400 billion provided for under the current Congressional Budget Resolution for implementing Medicare reform and providing a prescription drug benefit.

(7) Preserve the current employer-sponsored retiree health plans and not design a benefit which has the unintended consequences of supplanting private coverage.

(8) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(9 Restore the right of Medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the government contribution.

SA 1122. Mr. BROWNBACK (for himself, and Mr. NELSON of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals that furnish rural community hospital services to medicare beneficiaries.

(2) DESIGNATION OF RCHS.—

(A) APPLICATION.—Each hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) DESIGNATION.—The Secretary shall designate any hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section as a rural community hospital for purposes of the demonstration program.

(C) DEMONSTRATION AREAS.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) PAYMENT.—

(1) INPATIENT HOSPITAL SERVICES.—The amount of payment under the demonstration program for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge; or

(B) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(2) OUTPATIENT SERVICES.—The amount of payment under the demonstration program for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U) of the Social Security Act (42 U.S.C. 1395x(v)(1)(U)); or

(B) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(3) HOME HEALTH SERVICES.—In determining payments under the demonstration program for home health services furnished by a qualified RCH-based home health agency (as defined in paragraph (2))—

(A) the agency may make a one-time election to waive application of the prospective payment system established under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to such services furnished by the agency; and

(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(4) CONSOLIDATED BILLING.—The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(5) EXEMPTION FROM 30 PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—In determining the reasonable costs for rural community hospitals, section 1861(v)(1)(T) of the Social Security Act (42 U.S.C. 1395x(v)(1)(T)) shall not apply.

(6) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under the demonstration program shall be as follows:

(A) For items and services that would have been paid under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

(B) For items and services that would have been paid under section 1833(h) of such Act (42 U.S.C. 1395l(h)) if furnished by a provider or supplier, no cost-sharing shall apply.

(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.

(7) RETURN ON EQUITY.—

(A) IN GENERAL.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(B) SERVICES DESCRIBED.—The services referred to in subclause (I) are rural community hospital services.

(C) DISREGARD OF PROPRIETARY PROVIDER STATUS.—Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(8) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY RCH FACILITIES.—Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit rural community hospitals to establish distinct part units for purposes of applying such section.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) DEFINITIONS.—In this section:

(1) RURAL COMMUNITY HOSPITAL.—

(A) IN GENERAL.—The term ''rural community hospital'' means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to subparagraph (B), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services;

(iv) subject to subparagraph (C), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2003; and

(v) applies to the Secretary for such designation.

(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(C) TYPES OF HOSPITALS THAT MAY PARTICIPATE.—Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

(i) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) with the same service area (as defined by the Secretary in regulations in effect on such date).

(ii) A facility obtaining a new provider number pursuant to a change of ownership.

(iii) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2003.

(D) INCLUSION OF CAHS.—Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)) and section 1866 of such Act (42 U.S.C. 1395cc).

(2) QUALIFIED RCH-BASED HOME HEALTH AGENCY DEFINED.—The term ''qualified RCH-based home health agency'' is a home health agency that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554; Appendix F, 114 Stat. 2763A–506)) of a rural community hospital that is located—

(A) in a county in which no main or branch office of another home health agency is located; or

(B) at least 35 miles from any main or branch office of another home health agency.

SEC. ___. CRITICAL ACCESS HOSPITAL IMPROVEMENT DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF CRITICAL ACCESS HOSPITAL DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test various methods to improve the critical access hospital program under section 1820 of the Social Security Act (42 U.S.C. 1395i–4).

(2) CRITICAL ACCESS HOSPITAL IMPROVEMENT.—In conducting the demonstration program under this section, the Secretary shall apply rules with respect to critical access hospitals participating in the program as follows:

(A) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subsections (c)(2)(B)(iii) and (f) of section 1820 of the Social Security Act (42 U.S.C. 1395i–4), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.

(B) EXCLUSION FROM HOME HEALTH PPS.—Notwithstanding section 1895 of the Social Security Act (42 U.S.C. 1395fff), in determining payments under the demonstration program for home health services furnished by a home health agency that is owned and operated by a critical access hospital participating in the demonstration program—

(i) the agency may make an election to waive application of the prospective payment system established under such section to such services furnished by the agency; and

(ii) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(C) EXEMPTION OF CAH FACILITIES FROM PPS.—Notwithstanding section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), in determining payments under this part for covered skilled nursing facility services furnished by a skilled nursing facility that is a distinct part unit of a critical access hospital participating in the demonstration program or is owned and operated by a critical access hospital participating in the demonstration program—

(i) the prospective payment system established under such section shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(D) CONSOLIDATED BILLING.—The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(E) EXEMPTION OF CERTAIN DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS FROM COST LIMITS.—Notwithstanding section 1886(b) of the Social Security Act (42 U.S.C. 1395ww(b)), in determining payments under the demonstration program for inpatient hospital services furnished by a distinct part psychiatric or rehabilitation unit (described in the matter following section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v))) of a critical access hospital participating in the demonstration program—

(i) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(F) RETURN ON EQUITY.—

(i) IN GENERAL.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a critical access hospital participating in the demonstration program for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(ii) SERVICES DESCRIBED.—The services referred to in subclause (I) are inpatient critical access hospital services, outpatient critical access hospital services, extended care services, posthospital extended care services, home health services, ambulance services, and inpatient hospital services.

(iii) DISREGARD OF PROPRIETARY PROVIDER STATUS.—Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(G) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CAH FACILITIES.—Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit critical access hospitals participating in the demonstration program to establish distinct part units for purposes of applying such section.

(3) PARTICIPATION OF CAHS.—

(A) APPLICATION.—Each critical access hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) PARTICIPATION.—The Secretary shall permit any critical access hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section to participate in the demonstration program.

(C) DEMONSTRATION AREAS.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

(4) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(5) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(d) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

SA 1123. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. SENSE OF THE SENATE REGARDING THE PRESERVATION OF BENEFICIARY CHOICES UNDER MEDICAREADVANTAGE; ESTABLISHMENT OF STANDARDS.

(a) SENSE OF THE SENATE.—It is the sense of the Senate that medicare beneficiaries should have a choice among multiple types of health plans under the MedicareAdvantage program, including regional preferred provider organizations and local health maintenance organization plans in markets where such plans naturally occur.

(b) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards with respect to the participation of private health plans in the MedicareAdvantage program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) that—

(1) encourage fair competition among such plans;

(2) ensure that beneficiaries who desire to elect health benefits coverage under such a plan are provided with benefits that are actuarially equivalent to the benefits provided under other beneficiary options for health benefits coverage available under the medicare program; and

(3) equally apply incentives to promote health plan participation to all plans desiring to participate in the MedicareAdvantage program.

SA 1125. Mr. HATCH submitted an amendment intended to be proposed by him the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike title V and insert the following:

TITLE V—MEDICARE EDUCATION, REGULATORY REFORM, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 500. SHORT TITLE.

This title may be cited as the ''Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003''.

SEC. 501. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

''(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

''(C)(i) Except as provided in clause (ii), a substantive change may not take effect until not earlier than the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

SEC. 502. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 501(a)(1), is amended by adding at the end the following new subsection:

''(e)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of communications and correspondence, including the communications and correspondence required under section 1874A.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

SEC. 503. STATUS OF PENDING INTERIM FINAL REGULATIONS.

Section 1871 (42 U.S.C. 1395hh) as amended by sections 501 and 502, is amended by adding at the end the following new subsection:

''(f) The Secretary shall publish in the Federal Register at lease once every 6 months a list that provides the status of each interim final regulation for which no final regulation has been published. Such list shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.''.

Subtitle B—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF JUDGES.—The steps that should be taken to ensure that judges who perform the administrative law judge functions after the transfer under the plan maintain their independence from the Centers for Medicare & Medicaid Services and its contractors.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of judges performing the administrative law judge functions that are transferred under the plan throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire judges (and support staff) to perform the administrative law judge functions that are transferred under the plan.

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for judges performing the administrative law judge functions that are transferred under the plan with respect to timelines for decisions in cases under title XVIII.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to judges performing the administrative law judge functions that are transferred under the plan with respect to laws and regulations under title XVIII.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress a report on such evaluation.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision''; and

(2) by adding at the end the following new paragraph:

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review entity—

''(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that the Departmental Appeals Board does not have authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

''(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term 'review entity' means an entity of up to 3 qualified reviewers drawn from existing appeals levels other than the redetermination level.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

(2) by adding at the end the following new subparagraph:

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

''(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. COST REPORT REFORM.

(a) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives a report recommending specific ways to modernize the cost reporting system under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such report shall be consistent with the recommendations of the Secretary's Advisory Committee on Regulatory Reform, including the use of Generally Accepted Accounting Principles.

(b) CONSULTATION.—In developing the report submitted under subsection (a), the Secretary shall consult with representatives of the hospital industry, the Medicare Payment Advisory Commission, the General Accounting Office, and such other individuals and entities as the Secretary determines to be appropriate.

SEC. 514. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 515. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

''(3) TIMELY COMPLETION OF THE RECORD.—

''(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

''(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

''(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

''(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

''(i) written or testimonial evidence, or both, submitted by the person filing the request,

''(ii) written or oral argument, or both,

''(iii) the decision of, and the record for, the prior level of appeal, and

''(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.''.

(b) REVISIONS TO APPEALS TIMEFRAMES.—Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking ''30-day period'' each place it appears and inserting ''60-day period'';

(2) in subsection (c)(3)(C)(i), by striking ''30-day period'' and inserting ''60-day period'';

(3) in subsection (d)(1)(A), by striking ''90-day period'' and inserting ''120-day period''; and

(4) in subsection (d)(2)(A), by striking ''90-day period'' and inserting ''120-day period''.

(c) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(d) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

''(A) the reasons for the determination, including, as appropriate—

''(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

''(ii) upon request, in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

''(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

''(i) to the extent appropriate, an explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

''(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

''(iii) in the case of a determination of whether an item or service is reasonable and

necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the decision.''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

(B) by adding at the end the following new paragraph:

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

''(A) the specific reasons for the determination; and

''(B) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking ''such information as is required for an appeal'' and inserting ''the record for the appeal''.

(e) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting ''(except in the case of a utilization and quality control peer review organization, as defined in section 1152)'' after ''means an entity or organization that''; and

(ii) by striking the period at the end and inserting the following: ''and meets the following requirements:

''(A) GENERAL REQUIREMENTS.—

''(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

''(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

''(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''; and

(B) in paragraph (3)(A), by striking '', and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection''.

(2) ELIGIBILITY REQUIREMENTS OF REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) in subsection (c)(3)(B)(i), by striking ''a panel of physicians or other appropriate health care professionals'' and inserting ''a physician or another appropriate health care professional'';

(B) by striking subsection (c)(3)(D) and inserting the following:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

(C) by adding at the end the following new subsection:

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall ensure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review described in subsection (c)(3)(B) and conducted by a physician or another health care professional (each in this subsection referred to as a 'reviewing professional'), that the reviewing professional meets the qualifications described in paragraph (4).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) a nonaffiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''12'' and inserting ''4''.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

''(d) EFFECTIVE DATE.—

''(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after January 1, 2005.

''(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—The amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003 under the following provisions:

''(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

''(B) Subsection (c)(3)(C)(iii) of such section.

''(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

''(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.''.

(2) CONFORMING AMENDMENT.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 516. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

''(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

''(2) a provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of the enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 501, 502, and 503, is amended by adding at the end the following new subsection:

''(g) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.''.

SEC. 517. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination and the provider of services, physician, practitioner, or other supplier would be prejudiced by the determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 518. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

''(5) AGGRIEVED PARTY DEFINED.—In this section, with respect to a national or local coverage determination, the term 'aggrieved party' means—

''(A) an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; or

''(B) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.''.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting '', including, where appropriate, a clear explanation of the reasons for the denial'' before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 515(d)(2)(B), is amended by adding at the end the following new subsection:

''(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

''(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

''(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

''(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

''(B) each reversal described in subparagraph (A) involves substantially similar material facts;

''(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

''(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

''(4) APPROVAL OR REJECTION OF REQUEST.—

''(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

''(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.''.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after January 1, 2004;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of the enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and beneficiary services functions as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures, unless laws with general applicability to Federal acquisition and procurement or the Federal Acquisition Regulation authorize the use of other procedures, under such a contract not less frequently than once every 8 years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

''(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

''(B) CONSIDERATIONS.—The Secretary shall include, as one of the standards, provider and beneficiary satisfaction levels.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United

States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ''False Claims Act'').

''(5) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,'';

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor'';

(E) in paragraph (5), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier'' and ''carrier responses'' and inserting ''contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor'' and ''contractor responses'', respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for

functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

''(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

''(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

''(2) IG REVIEW OF METHODOLOGY.—The Inspector General of the Department of Health and Human Services shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

''(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.''.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)'';

(B) in subparagraph (B), by striking ''The amount appropriated'' and inserting ''Subject to subparagraph (C), the amount appropriated''; and

(C) by adding at the end the following new subparagraph:

''(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

''(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

''(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.''.

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

''(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

''(c) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

''(d) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

''(1) of the screens used for identifying claims that will be subject to medical review; or

''(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

''(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

''(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare

contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within a contractual timeframe established by the Secretary.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

''(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2004.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).

SEC. 533. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 501, is amended by adding at the end the following new paragraph:

''(2) If—

''(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

''(i) by the Secretary; or

''(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

''(B) the Secretary determines that—

''(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

''(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

''(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of the enactment of this Act.

SEC. 534. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

''(b) MEDICARE PROVIDER OMBUDSMAN.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman who shall have experience in health care. The Ombudsman shall—

''(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration);

''(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers; and

''(C) recommendations to improve communication between providers, contractors, and the Centers for Medicare & Medicaid Services.

''(c) STAFF.—The Secretary shall provide appropriate staff to assist in performing the duties described in subsection (b).''.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1807. (a) IN GENERAL.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman (including support staff) who shall have expertise and experience in the fields of health care and advocacy.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

''(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

''(B) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

''(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.''.

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists

employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 3 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local social security offices.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

''(g) CONDUCT OF PREPAYMENT REVIEW.—

''(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

''(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of the enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

''(h) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

''(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

''(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) PAYMENT OF INTEREST.—

''(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

''(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

''(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

''(3) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

''(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

''(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be over utilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

''(6) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

''(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of the enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of over-utilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of the enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

SEC. 545. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(f) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

''(1) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

''(2) documented educational intervention has failed to correct the payment error (as determined by the Secretary).''.

(b) EFFECTIVE DATE.—Section 1893(f) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services and inpatient hospital services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking ''hospice services'' and inserting ''hospice care and post-hospital extended care services''; and

(B) by inserting before the period at the end the following: ''and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management physician services under title XVIII of Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 554. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 301(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians

and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

(b) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

''(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

''(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

''(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

''(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

''(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

''(i) set forth the criteria for making determinations under subparagraph (A); and

''(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

''(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

''(E) For purposes of this paragraph:

''(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

''(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).''.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

SEC. 555. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 556. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(B) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 557. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the ''Advisory Group'') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 558. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) In extraordinary, exigent, or other nonroutine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services provided by or under the supervision of a registered professional nurse and are provided nonroutinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 559. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

(3) by inserting after paragraph (4) the following new paragraph:

''(5) for individuals who are terminally ill and who have not made an election under subsection (d)(1), services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

''(A) an evaluation of the individual's need for pain and symptom management, including the need for hospice care;

''(B) counseling the individual with respect to end-of-life issues, the benefits of hospice care, and care options; and

''(C) if appropriate, advising the individual regarding advanced care planning.''.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under part A shall be the amount determined under a fee schedule established by the Secretary.''.

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: ''and services described in section 1812(a)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 560. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking ''and'' at the end;

(B) in subparagraph (S), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 or a State occupational safety and health plan that is approved under section 18(b) of such Act, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

(2) by adding at the end of subsection (b) the following new paragraph:

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 561. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy'' and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking ''subclause (I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 562. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

''(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 563. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: ''(ii) where the service was provided under a contractual arrangement between such physician or other person and a qualified entity (as defined by the Secretary) or other person, to the entity or other person if under such arrangement such entity or individual submits the bill for such service and such arrangement (I) includes

joint and several liability for overpayment by such physician or other person and such entity or other person, and (II) meets such other program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENTS.—

(1) The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility as described in clause (A)'' and inserting ''except to an employer, entity, or other person as described in subparagraph (A)''.

(2) Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: ''Nothing in subparagraph (A)(ii) shall be construed to prohibit requirements for joint and several liability for contractual arrangements where such requirements are not explicitly stated in a statute.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after 1 year after the date of the enactment of this Act.

SEC. 564. GAO STUDY AND REPORT REGARDING ILLINOIS COUNCIL DECISION.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the access of health care providers and beneficiaries under the medicare program under title XVIII of the Social Security Act to judicial review of the actions of the Secretary of Health and Human Services and the effects of the decision of the Supreme Court of the United States in Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (1999) on such access.

(a) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

SA 1126. Mrs. DOLE (for herself, and Mr. EDWARDS) submitteed an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) BUDGET NEUTRAL WITHIN NORTH CAROLINA.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such payments that would have been made in the year if this subsection had not been enacted.

(b) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act, Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) APPLICATION AND BUDGET NEUTRAL WITHIN NORTH CAROLINA.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be implemented in a budget neutral manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the total amount of expenditures that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(c) CONSTRUCTION.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

SA 1127. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. BRACHYTHERAPY DEVICES.

(a) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(1) in subparagraph (F), by striking ''and'' at the end;

(2) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(H) with respect to devices of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number of such devices furnished separately for palladium-103 and iodine-125.''.

(b) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(13)(B) of the Social Security Act, as added by subsection (a), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this subsection, and shall include specific recommendations for appropriate payments for such devices.

SA 1128. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 133, after line 25, insert the following:

''(3) COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

''(B) ELECTION.—Under the process established under section 1860D–3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or MedicareAdvantage plan through the existing State pharmaceutical assistance program.

''(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—In this paragraph, the term 'existing State pharmaceutical assistance program' means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004.

SA 1129. Mr. DASCHLE (for Mr. KERRY) submitted an amendment intended to be proposed by Mr. DASCHLE to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING PARITY OF MENTAL HEALTH SERVICES UNDER MEDICARE.

(a) FINDINGS.—The Senate finds the following:

(1) Beneficiaries of the Medicare program under title XVIII of the Social Security Act pay 50 percent coinsurance for outpatient psychiatric services.

(2) In comparison, such beneficiaries pay 20 percent coinsurance for all other medical services.

(3) There is no scientific or medical justification for this discriminatory inequity.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Congress should work to achieve parity under the Medicare program under title XVIII of the Social Security Act between mental health services and other medical services as soon as practicable.

SA 1130. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill to S. 1, to amend title XVIII of the Social Security Act to

provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table, as follows:

At the appropriate place in title II, insert the following:

SEC. ___. STUDY ON TRENDS IN EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.

(a) STUDY.—The Comptroller General of the United States, in consultation with employers, health benefit experts, academia, human resource professionals, State and local government officials, and employer consulting firms, shall conduct a study to determine the effect of the amendments made by this Act on the provision of employment-based retiree health coverage (as such term is defined in section 1860D-20(e)(4)(B) of the Social Security Act). Such study shall examine the following:

(1) Trends in employment-based retiree health coverage, as such trends relate to retirees who are eligible for coverage under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) The extent to which health care coverage, including coverage under Medicare+Choice, MedicareAdvantage, and fee-for-service prescription drug plans under the medicare program, are available to retirees who are eligible for coverage under the medicare program.

(3) The extent to which geographic location plays a role in the structure and availability of retiree health benefit coverage.

(4) Whether incentives built into this Act (and the amendments made by this Act) are sufficient to induce employers to maintain employment-based retiree health coverage, and whether other voluntary incentives exist to encourage employers to maintain such coverage.

(5) Whether obstacles exist to employers providing employment-based retiree health coverage, including administrative burden, the cost of prescription drugs, and the increasing overall health care costs.

(6) Whether—

(A) employment-based retiree health coverage has changed because of the implementation of the MedicareAdvantage and medicare fee-for-service programs under the amendments made by this Act;

(B) such coverage continues to maintain the employment-based retiree health benefit packages that were available prior to the implementation of such programs;

(C) employers conduct health fairs or provide other educational opportunities for their retirees to encourage retirees to obtain coverage under MedicareAdvantage or other prescription drug plans that are available; and

(D) employers offer retirees financial incentive to obtain coverage under MedicareAdvantage or other prescription drug plans, including premium subsidies.

(7) Whether the availability of MedicareAdvantage and medicare fee-for-service prescription drug coverage acts as an incentive to employers that did not previously offer employment-based retiree health coverage to offer such coverage to retirees.

(8) Whether other tools are used by employers to help future employees afford health benefits and prescription drug coverage once such employees reach retirement age.

(b) INFORMATION.—In conducting the study under subsection (a), the Comptroller General shall determine the effect of the amendments made by this Act on the provision of employment-based retiree health coverage using information available for the period—

(1) beginning on the date of enactment of this Act and ending on January 1, 2005; and

(2) beginning on January 1, 2006 and ending on January 1, 2007.

(c) REPORT.—Not later than July 1, 2007, the Comptroller General shall submit to the Secretary and the appropriate committees of Congress a report based on the study conducted under subsection (a).

SA 1131. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES.

(a) IN GENERAL.—The Secretary shall revise the regulation promulgated under section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–350) so that, in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4), the Secretary recognizes all costs of clinical staff employed by cardio-thoracic surgeons (net of any reimbursements for staff for whom there is direct reimbursement under part B of such Act (42 U.S.C. 1395j et seq.)), regardless of the site at which such costs are incurred and notwithstanding any other provision of law or regulation. For purposes of revising such regulation, the Secretary shall use validated data collected by organizations and entities (other than the Department of Health and Human Services) on all costs incurred by physicians, including data from the Socioeconomic Monitoring System of the American Medical Association and from supplemental surveys accepted by the Department of Health and Human Services as consistent with sound data practices prior to the date of enactment of this Act.

(b) EFFECTIVE DATE.—The regulation revised under subsection (a) shall apply with respect to payments for physicians' services furnished on and after January 1, 2004.

SA 1132. Mr. SANTORUM proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; as follows:

On page 343, between lines 15 and 16, insert the following:

''(f) ZERO PREMIUM STOP-LOSS PROTECTION AND ACCESS TO NEGOTIATED PRICES FOR ELIGIBLE BENEFICIARIES ENROLLED IN MEDICAREADVANTAGE PLANS.—

''(1) IN GENERAL.—Notwithstanding any provision of this part or part D, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage otherwise required, the plan makes available such coverage with the following modifications:

''(A) NO PREMIUM.—Notwithstanding subsection (d) or sections 1860D–13(e)(2) and 1860D–17, the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage shall be zero.

''(B) BENEFICIARY RECEIVES ACCESS TO NEGOTIATED PRICES AND STOP-LOSS PROTECTION FOR NO ADDITIONAL PREMIUM.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

''(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

''(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4), except that in applying such subsection, '$___' shall be substituted for '$3,700' in subparagraph (B)(i)(I) of such subsection.

''(iii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

''(C) APPLICATION OF LOW-INCOME SUBSIDIES.—Notwithstanding subsection (f) or section 1860D–19, the Administrator shall not apply the following provisions of subsection (a) of such section:

''(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

''(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

''(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

''(2) PENALTY FOR ENROLLING IN A ZERO PREMIUM STOP-LOSS PROTECTION PLANS AFTER INITIAL ELIGIBILITY FOR SUCH ENROLLMENT.—In the case of an eligible beneficiary that enrolled in a plan offered pursuant to this subsection at any time after the initial enrollment period described in section 1860D–2, the Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under such a plan but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under this paragraph in a manner that is similar to the manner such provisions apply to the penalty under part D.

''(3) PROCEDURES.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this subsection.

''(4) NO EFFECT ON MEDICARE DRUG PLANS.—This subsection shall have no effect on eligible beneficiaries enrolled under part D in a Medicare Prescription Drug plan or under a contract under section 1860D–13(e).''

SA 1133. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 8, line 12, insert ''(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator)'' before the semicolon.

On page 46, line 9, after the end period insert: ''Such requirement shall not apply to

enrollees of a Medicare Prescription Drug plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement.''

On page 51, line 19, insert ''(but only with respect to the percentage of such costs that the individual is responsible for under that section)'' after ''1860D–19''.

On page 56, strike lines 3 through 19, and insert the following:

''(B) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part—

''(i) the medical assistance for such a drug shall be disregarded for purposes of a rebate agreement entered into under section 1927 which would otherwise apply to the provision of medical assistance for the drug under title XIX; and

''(ii) the prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a MedicareAdvantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

On page 74, strike lines 14 through 16, and insert the following:

the plan;

''(D) the average aggregate projected cost of covered drugs under the plan relative to other Medicare Prescription Drug plans and MedicareAdvantage plans; or

''(E) other factors determined appropriate by the Administrator.

Beginning on page 88, strike lines 9 through page 89, line 10, and insert the following:

''(ii) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under clause (i) for the year—

''(I) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

''(II) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The amount under subparagraph (A)(i) may not include—

''(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

''(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2);

''(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20; or

''(iv) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in subparagraph (A)(i).

On page 78, beginning on line 20, strike ''An entity'' and all that follows through line 24.

On page 84, line 6, strike ''(including a contract under)''.

Beginning on page 92, strike line 20 through page 93, line 25, and insert the following:

''(3) ESTABLISHMENT OF ALLOWABLE COSTS.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year.

On page 116, strike lines 11 and 12, and insert the following:

''(ii) is eligible for medicare cost-sharing described in section 1905(p)(3) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1905(p)(1), as determined under such plan (or under a waiver of plan); and

On page 117, strike lines 1 and 2, and insert the following:

''(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iii), as determined under such plan (or under a waiver of plan); and

On page 117, strike lines 14 through 17, and insert the following:

''(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX), as determined under such plan (or under a waiver of such plan); and

On page 120, line 11, strike ''such individuals'' and insert ''in the case of such an individual who is not a resident of the 50 States or the District of Columbia, such individual''.

Beginning on page 123, strike line 10 through page 124, line 6, and insert the following:

''(B) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under subparagraph (A) for the year—

''(i) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

''(ii) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

''(2) CERTAIN EXPENSES NOT INCLUDED.—The amount under paragraph (1)(A) may not include—

''(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A);

''(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2); or

''(C) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in paragraph (1)(A).

On page 124, on line 15, insert ''(or 65 percent with respect to a qualifying covered individual described in subsection (e)(2)(D))'' after ''80 percent''.

Beginning on page 124, strike line 18 through page 125, line 13, and insert the following:

''(2) ESTABLISHMENT OF ALLOWABLE COSTS.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year.

Beginning on page 126, strike line 7 through page 127, line 9, and insert the following:

''(2) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled in this part and in a Medicare Prescription Drug plan;

''(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage);

''(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan; or

''(D) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified State pharmaceutical assistance program.

''(3) QUALIFYING ENTITY.—The term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

''(B) A MedicareAdvantage organization offering a MedicareAdvantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

''(C) The sponsor of a qualified retiree prescription drug plan.

''(D) A State offering a qualified State pharmaceutical assistance program.

On page 127, beginning with line 18, strike all through page 128, line 2, and insert:

''(i) ATTESTATION OF ACTUARIAL VALUE OF COVERAGE.—The sponsor of the plan shall, annually or at such other time as the Administrator may require, provide the Administrator an attestation, in accordance with the procedures established under section 1860D–6(f), that the actuarial value of prescription drug coverage under the plan is at least equal to the actuarial value of standard prescription drug coverage.

''(ii) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Administrator access to) such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this part to and by the plan.

On page 128, between lines 12 and 13, insert the following:

''(6) QUALIFIED STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—

''(A) IN GENERAL.—The term 'qualified State pharmaceutical assistance program' means a State pharmaceutical assistance program if, with respect to a qualifying covered individual who is covered under the program, the following requirements are met:

''(i) ASSURANCE.—The State offering the program shall, annually or at such other times as the Administrator may require, provide the Administrator an attestation that, in accordance with the procedures established under section 1860D–6(f), that—

''(I) the actuarial value of prescription drug coverage under the program is at least equal to the actuarial value of standard prescription drug coverage; and

''(II) the actuarial value of subsidies to individuals provided under the program are at least equal to the actuarial value of the subsidies that would apply under section 1860D–19 if the individual was enrolled under this part rather than under the program.

''(ii) DISCLOSURE OF INFORMATION.—The State complies with the requirements described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

''(B) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—For purposes of subparagraph (A), the term 'State pharmaceutical assistance program' means a program—

''(i) that is in operation as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003;

''(ii) that is sponsored and financed by a State; and

''(iii) that provides coverage for outpatient drugs for individuals in the State who meet income- and resource-related qualifications specified under such program.

On page 128, between lines 15 and 16, insert the following:

''(g) DISTRIBUTION OF REINSURANCE PAYMENT AMOUNTS.—

''(1) IN GENERAL.—Any sponsor meeting the requirements of subsection (e)(3) with respect to a quarter in a calendar year, but which is not an employer, shall distribute the reinsurance payments received for such quarter under subsection (c) to the employers contributing to the qualified retiree prescription drug plan maintained by such sponsor during that quarter, in the manner described in paragraphs (2) and (3).

''(2) ALLOCATION.—The reinsurance payments to be distributed pursuant to paragraph (1) shall be allocated proportionally among all employers who contribute to the plan during the quarter with respect to which the payments are received. The share allocated to each employer contributing to the plan during a quarter shall be determined by multiplying the total reinsurance payments received by the sponsor for the quarter by a fraction, the numerator of which is the total contributions made by an employer for that quarter, and the denominator of which is the total contributions required to be made to the plan by all employers for that quarter. Any share allocated to an employer required to contribute for a quarter who does not make the contributions required for that quarter on or before the date due shall be retained by the sponsor for the benefit of the plan as a whole.

''(3) TIMING.—Reinsurance payments required to be distributed to employers pursuant to this subsection shall be distributed as soon as practicable after received by the sponsor, but in no event later than the end of the quarter immediately following the quarter in which such reinsurance payments are received by the sponsor.

''(4) REGULATIONS.—The Secretary shall promulgate regulations providing that any sponsor subject to the requirements of this subsection who fails to meet such requirements shall not be eligible for a payment under this section.

On page 130, between lines 7 and 8, insert the following:

''DIRECT SUBSIDIES FOR QUALIFIED STATE OFFERING A STATE PHARMACEUTICAL ASSISTANCE PROGRAM FOR PROGRAM ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

''SEC. 1860D–22. (a) DIRECT SUBSIDY.—

''(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical assistance program (as defined in section 1860D–20(e)(6)) for each qualifying covered individual (described in subparagraph (D) of section 1860D–(e)(2)) enrolled in the program for each month for which such individual is so enrolled.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the amount of payment for the area and year made under section 1860D–21(a)(2).

''(b) ADDITIONAL SUBSIDY.—

''(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical program (as defined in section 1860D–20(e)(6)) for each applicable low-income individual enrolled in the program for each month for which such individual is so enrolled.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be the amount the Administrator estimates would have been made to an entity or organization under section 1860D–19 with respect to the applicable low-income individual if such individual was enrolled in this part and under a Medicare Prescription Drug plan or a MedicareAdvantage plan.

''(B) MAXIMUM PAYMENTS.—In no case may the amount of the payment determined under subparagraph (A) with respect to an applicable low-income individual exceed, as estimated by the Administrator, the average amounts made in a year under section 1860D–19 on behalf of an eligible beneficiary enrolled under this part with income that is the same as the income of the applicable low-income individual.

''(3) APPLICABLE LOW-INCOME INDIVIDUAL.—For purposes of this subsection, the term 'applicable low-income individual' means an individual who is both—

''(A) a qualifying covered individual (described in subparagraph (D) of section 1860D–(e)(2)); and

''(B) a qualified medicare beneficiary, a specified low income medicare beneficiary, or a subsidy-eligible individual, as such terms are defined in section 1860D–19(a)(4).

''(c) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

''(d) CONSTRUCTION.—Nothing in this section or section 1860D–20 shall effect the provisions of section 1860D–26(b).

On page 134, between lines 9 and 10, insert:

''(d) WAIVER AUTHORITY.—The Secretary shall have authority similar to the waiver authority under section 1857(i) to facilitate the offering of Medicare Prescription Drug plans by employer or other group health plans as part of employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)), including the authority to establish separate premium amounts for enrollees in a Medicare Prescription Drug plan by reason of such coverage.''

On page 142, beginning on line 16, strike ''in a manner'' and all that follows through line 19 and insert a semicolon.

On page 143, beginning on line 15, strike ''in a manner'' and all that follows through line 18 and insert a semicolon.

On page 144, between lines 10 and 11, insert the following:

''(4) SCREEN AND ENROLL INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—As part of making an eligibility determination required under paragraph (1) or (2), screen an individual who applies for such a determination for eligibility for medical assistance for any medicare cost-sharing described in section 1905(p)(3) and, if the individual is eligible for any such medicare cost-sharing, enroll the individual under the State plan (or under a waiver of such plan).

On page 147, line 1, insert ''and notwithstanding section 1905(b),'' after ''(4)''.

On page 147, beginning on line 6, strike ''Secretary'' and all that follows through ''paying'' on line 8, and insert ''Federal medical assistance percentage shall be''.

On page 147, line 8, strike ''of the'' and insert ''for''.

On page 147, strike lines 13 through 16, and insert the following:

''(B) whose income is at least the income required for an individual to be an eligible individual under section 1611 for purposes of the supplemental security income program (as determined under section 1612), but does not exceed 100 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.,

On page 149, line 1, insert ''and notwithstanding section 1905(b),'' after ''(2)''.

On page 149, beginning on line 6, strike ''Secretary'' and all that follows through ''paying'' on line 8, and insert ''Federal medical assistance percentage shall be''.

On page 149, line 8, strike ''of the'' and insert ''for''.

On page 151, line 9, strike ''$22,500,000'' and insert ''$37,500,000''.

On page 151, line 11, strike ''$30,000,000'' and insert ''$50,000,000''.

On page 152, strike lines 8 through 11, and insert the following:

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting ''and subsections (c)(1) and (d)(1) of section 1935'' after ''1933(d)''.

(B) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

On page 157, line 17, strike ''and''.

On page 157, line 20, strike the period and insert ''; and''.

On page 157, between lines 20 and 21, insert the following:

(C) by adding at the end the following:

''(3) AGREEMENTS TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD OFFICES.—

''(A) IN GENERAL.—The Commissioner shall enter into an agreement with each State operating a State plan under title XIX (including under a waiver of such plan) to establish information and enrollment sites within all the Social Security field offices located in the State for purposes of—

''(i) the State determining the eligibility of individuals residing in the State for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933, the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19; and

''(ii) enrolling individuals who are determined eligible for such medical assistance, program, or subsidies in the State plan (or waiver), the transitional prescription drug assistance card program under section 1807A, or the appropriate category for premium and cost-sharing subsidies under section 1860D–19.

''(B) AGREEMENT TERMS.—The Secretary and the Commissioner jointly shall develop terms for the State agreements required under subparagraph (A) that shall specify the responsibilities of the State and the Commissioner in the establishment and operation of such sites.

''(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Commissioner, such sums as may be necessary to carry out this paragraph.''.

On page 159, line 19, insert the following before the closing quotation: ''As part of such review, the Commission shall hold 3 field hearings in 2007.''.

On page 174, line 14, insert ''(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Secretary)'' before the comma.

Beginning on page 195, strike line 16 through page 196, line 7, and insert the following:

''(A) PATIENT MAY REQUEST A WRITTEN PRESCRIPTION.—The standards provide that—

''(i) a prescription shall be written and not transmitted electronically if the patient makes such a request; and

''(ii) no additional charges may be imposed on the patient for making such a request.

On page 199, strike lines 10 through 14, and insert the following:

''(A) IN GENERAL.—Individuals or entities that transmit or receive prescriptions electronically shall comply with the standards adopted or modified under this part.

On page 200, between lines 16 and 17, insert the following:

''(e) NO REQUIREMENT TO TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—Nothing in this part shall be construed to require an individual or entity to transmit or receive prescriptions electronically.

On page 254, line 25, insert ''(other than deemed contracts or agreements under subsection (j)(6))'' before ''with a sufficient number''.

On page 255, line 7, before the period, insert the following: '', except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan''.

On page 297, strike lines 5 through 9, and insert the following:

''(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting '102' for '103' in clause (v).

On page 323, strike lines 1 through 3, and insert the following:

''(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3), or, with respect to a private fee-for-service plan (as described in section 1851(a)(2)(C)) under subparagraph (A)(i), (A)(ii)(III), or (B) of paragraph (2).

On page 326, line 11, after the end period insert: ''Subject to the provisions of section 1858(h), such requirement shall not apply to enrollees of a MedicareAdvantage plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement.''.

On page 328, line 3, strike ''or (C)''.

On page 328, line 20, strike ''or (C)''.

On page 343, strike lines 22 through 24, and insert:

Section 1858(h) (as added by section 211) is amended—

(1) by inserting ''(including subsection (i) of such section)'' after ''section 1857''; and

(2) by adding at the end the following new sentence: ''In applying the authority under section 1857(i) pursuant to this subsection, the Administrator may permit MedicareAdvantage plans to establish separate premium amounts for enrollees in an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)).''

On page 349, between lines 4 and 5, insert the following:

(3) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

''(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting '102' for '103' in clause (v).''.

On page 379, strike lines 9 through 13, and insert:

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

''(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

''(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

Beginning on page 411, strike line 5 through page 414, line 9, and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to subclause (II), for discharges''; and

(2) by adding at the end the following new subclause:

''(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) APPLICATION TO SUBSECTION (D) PUERTO RICO HOSPITALS.—Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' after the comma at the end;

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''and before October 1, 2003'' after ''October 1, 1997''; and

(ii) in the matter following clause (III), by striking the period at the end and inserting '', and''; and

(iii) by adding at the end the following new clause:

''(iii) for discharges in a fiscal year beginning on or after October 1, 2003, 50 percent of the national standardized rate (determined under paragraph (3)(D)(iii)) for hospitals located in any area.'';

(2) in subparagraph (C)—

(A) in clause (i)—

(i) by striking ''(i) The Secretary'' and inserting ''(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary; and

(ii) by adding at the end the following:

''(II) For discharges in fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in an urban area, increased by the applicable percentage increase under subsection (b)(3)(B) for fiscal year 2004.

''(III) For discharges in a fiscal year after fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any are of Puerto Rico that is equal to the average standardized amount computed under subclause (II) or this subclause for the previous fiscal year, increased by the applicable percentage increase under subsection (b)(3)(B), adjusted to reflect the most recent case mix data.'';

(B) in clause (ii), by inserting ''(or for fiscal year 2004 and thereafter, the standardized amount)'' after ''each of the average standardized amounts''; and

(C) in clause (iii)(I), by striking ''for hospitals located in an urban or rural area, respectively''.

(c) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new clause:

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

On page 430, strike lines 19 through 21, and insert the following:

(b) PERMITTING NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CLINICAL NURSE SPECIALIST TO REVIEW HOSPICE PLANS OF CARE.—Section 1814(a)(7)(B) is amended by inserting ''(or by a physician assistant, nurse practitioner or clinical nurse specialist who is not an employee of the hospice program, and whom the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care)'' after ''and is periodically reviewed by the individual's attending physician''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care furnished on or after October 1, 2004.

On page 438, between lines 10 and 11, insert the following:

SEC. 414. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking ''and'' after the semicolon at the end;

(2) in subclause (VII)—

(A) by striking ''on or after October 1, 2002'' and inserting ''during fiscal year 2003''; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subclauses:

''(VIII) during each of fiscal years 2004 and 2005, 'c' is equal to 1.36; and

''(IX) on or after October 1, 2005, 'c' is equal to 1.355.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

(2) by inserting '', or the Prescription Drug and Medicare Improvement Act of 2003'' after ''2000''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 415. CALCULATION OF WAGE INDICES FOR HOSPITALS.

(a) IN GENERAL.—Notwithstanding any other provision of law, in the calculation of a wage index in a State for purposes of making payments for discharge waive such other criteria for re-classification as deemed appropriate by the Secretary.

SEC. 416. CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting ''(which regulations shall exclude any cost incurred for the provision of services pursuant to a contract with an eligible entity (as defined in section 1860D(4)) operating a Medicare Prescription Drug plan or with an entity with a contract under section 1860D–13(e), for which payment is made by the entity)'' after ''the Secretary may prescribe in regulations''.

SEC. 417. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) DISPROPORTIONATE SHARE ADJUSTMENT PERCENTAGE.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking ''35 percent'' and inserting ''35 percent (or, for discharges occurring on or after October 1, 2003, 40 percent)''.

(b) CAPITAL COSTS.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv), by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following new clause:

''(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).''.

SEC. 418. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—The last sentence of section 1886(d)(1)(B) is amended by inserting '', and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)'' before the period at the end.

(b) TREATMENT OF PROPOSED REVISION.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) EFFECTIVE DATE.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

On page 440, line 2, insert closing quotation marks and a period after the period at the end.

Beginning on page 441, strike line 19 and all that follows through page 442, line 2.

Beginning on page 445, strike line 5 and all that follows through page 446, line 6, and insert the following:

SEC. 426. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2005, and before January 1, 2008, for which the transportation originates in—

''(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

''(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent.

''(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

''(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.''.

Beginning on page 470, strike line 21 and all that follows through page 471, line 13, and insert the following:

''(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased by 1.6 percent.

''(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent and further increased by 1.6 percent.

''(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 and all subsequent years, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year, increased by 0.05 percent.

On page 486, line 3, insert ''and'' after the semicolon at the end.

On page 486, line 4, insert ''(I)'' after ''(ii)''.

On page 486, line 8, strike ''and'' and insert ''or''.

On page 486, line 9, strike ''(iii)'' and insert ''(II)''.

On page 488, after line 25, add the following:

(c) LIMITATION OF EXPENDITURES IN YEARS PRIOR TO 2014.—

(1) IN GENERAL.—The Secretary shall ensure that the total amount of expenditures under title XVIII of the Social Security Act (including amounts expended by reason of this section) in a year prior to 2014 does not exceed the sum of—

(A) the total amount of expenditures under such title XVIII that would have made if this section had not been enacted; and

(B) the applicable amount.

(2) APPLICABLE AMOUNT.—For purposes of paragraph (1), the term ''applicable amount'' means—

(A) for 2005, $32,000,000;

(B) for 2006, $34,000,000;

(C) for 2007, $36,000,000;

(D) for 2008, $38,000,000;

(E) for 2009, $40,000,000;

(F) for 2010, $42,000,000;

(G) for 2011, $44,000,000;

(H) for 2012, $48,000,000; and

(I) for 2013, $50,000,000.

(3) STEPS TO ENSURE FUNDING LIMITATION NOT VIOLATED.—If the Secretary determines that the application of this section will result in the funding limitation described in paragraph (1) being violated for any year, the Secretary shall take appropriate steps to stay within such funding limitation, including through limiting the number of clinical trials deemed under subsection (a) and only covering a portion of the routine costs described in such subsection.

On page 516, after line 22, add the following:

SEC. 446. AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) IN GENERAL.—Section 1880(e) (42 U.S.C. 1395qq(e)) is amended—

(1) in paragraph (1)(A), by striking ''for services described in paragraph (2)'' and inserting ''for all items and services for which payment may be made under such part'';

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

SEC. 447. COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V)(iii), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(W) cardiovascular screening tests (as defined in subsection (ww)(1));''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Cardiovascular Screening Tests

''(ww)(1) The term 'cardiovascular screening tests' means the following diagnostic tests for the early detection of cardiovascular disease:

''(A) Tests for the determination of cholesterol levels.

''(B) Tests for the determination of lipid levels of the blood.

''(C) Such other tests for cardiovascular disease as the Secretary may approve.

''(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

''(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years.''.

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 448. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

''(ii) a self-injected drug that is used to treat multiple sclerosis;''.

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting '', except for any drug or biological described in subparagraph (W),'' after ''which''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

SEC. 449. EXTENSION OF MEDICARE SECONDARY PAYER RULES FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.

Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting '', and before January 1, 2004'' after ''prior to such date)''; and

(2) by adding at the end the following new sentence: ''Effective for items and services furnished on or after January 1, 2004 (with respect to periods beginning on or after June 1, 2002), clauses (i) and (ii) shall be applied by substituting '36-month' for '12-month' each place it appears in the first sentence.

SEC. 450. REQUIRING THE INTERNAL REVENUE SERVICE TO DEPOSIT INSTALLMENT AGREEMENT AND OTHER FEES IN THE TREASURY AS MISCELLANEOUS RECEIPTS.

Notwithstanding any other provision of law, the Secretary of the Treasury is required to deposit in the Treasury as miscellaneous receipts any fee receipts, including fees from installment agreements and restructured installment agreements, collected under the authority provided by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-329, the Treasury, Postal Service and General Government Appropriations Act, 1995. Fees collected under this section shall be available for use by the Internal Revenue Service only to the extent that such authority is provided in advance in an appropriations Act.

SEC. 450A. INCREASING TYPES OF ORIGINATING TELEHEALTH SITES AND FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

''(VI) A skilled nursing facility (as defined in section 1819(a)).

''(VII) An assisted-living facility (as defined by the Secretary).

''(VIII) A board-and-care home (as defined by the Secretary).

''(IX) A county of community health clinic (as defined by the Secretary).

''(X) A community mental health center (as described in section 1861(ff)(2)(B)).

''(XI) A long-term care facility (as defined by the Secretary).

''(XII) A facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) directly, or under contract or other arrangement.''.

(b) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—

(1) IN GENERAL.—For purposes of expediting the provision of telehealth services for which payment is made under the medicare program under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), across State lines, the Secretary shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of State provisions allowing for multistate practitioner licensure across State lines.

(2) DEFINITIONS.—In this subsection:

(A) TELEHEALTH SERVICE.—The term ''telehealth service'' has the meaning given that term in subparagraph (F)(i) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(B) PHYSICIAN, PRACTITIONER.—The terms ''physician'' and ''practitioner'' have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(C) MEDICARE PROGRAM.—The term ''medicare program'' means the program of health insurance administered by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 450B. DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term ''surgical first assisting services'' means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term ''certified registered nurse first assistant'' means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) PAYMENT RATES.—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) for the same services if furnished by a physician.

(d) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in 5 States selected by the Secretary.

(e) DURATION.—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the project under this section.

(2) BUDGET NEUTRALITY.—In conducting the project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the project under this section was not implemented.

(i) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 450C. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SEC. 450D. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(b) (42 U.S.C. 1395w–4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

(2) by adding at the end the following new paragraph:

''(4) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.—

''(A) IN GENERAL.—With respect to physicians' services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, the fee schedule for such services shall be determined as follows:

''(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

''(I) in the case of services furnished in calendar year 2004, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

''(II) in the case of services furnished in calendar year 2005, the amount determined under subclause (I) for 2004, increased by the annual update determined under subsection (d) for the year involved.

''(ii) In the case of a service for which there was no VA Alaska fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to the sum of—

''(I) the amount of payment for the service that would otherwise apply under this section; plus

''(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

''(B) VA ALASKA FEE SCHEDULE AMOUNT.—For purposes of this paragraph, the term 'VA Alaska fee schedule amount' means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians' services associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38.

''(C) APPLICABLE PERCENT.—For purposes of this paragraph, the term 'applicable percent' means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount for physicians' services exceeded the amount of payment for such services under this section that applied in Alaska in 2001.''.

SEC. 450E. DEMONSTRATION PROJECT TO EXAMINE WHAT WEIGHT LOSS WEIGHT MANAGEMENT SERVICES CAN COST EFFECTIVELY REACH THE SAME RESULT AS THE NIH DIABETES PRIMARY PREVENTION TRIAL STUDY: A 50 PERCENT REDUCTION IN THE RISK FOR TYPE 2 DIABETES FOR INDIVIDUALS WHO HAVE IMPAIRED GLUCOSE TOLERANCE AND ARE OBESE.

(a) IN GENERAL.—Inasmuch as the NIH Diabetes Primary Prevention Trial study proved that the risk of type 2 diabetes could be cut in half when the Institute of Medicine definition of successful weight loss (5 percent weight loss maintained for a year) is achieved by individuals at risk for type 2 diabetes due to obesity and impaired glucose tolerance, the Secretary shall conduct a demonstration project to examine the cost effectiveness and health benefits of providing group weight loss management services to achieve the same result for beneficiaries under the medicare program under title XVIII of the Social Security Act who are obese and have impaired glucose tolerance.

(b) LIMITATION.—The cost of the group weight loss management services provided under subsection (a) shall not exceed the cost per recipient per year of the medical nutritional therapy benefit currently available to medicare beneficiaries.

(c) SCOPE OF SERVICES.—

(1) DURATION.—The project shall be conducted for a period of 2 fiscal years.

(2) SITES.—The Secretary shall designate the sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in—

(A) rural areas; or

(B) areas that have a high concentration of Native Americans with type 2 diabetes.

(3) FUNDING.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(B) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $2,500,000 for each fiscal year in which the project is conducted under paragraph (1).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, medical nutrition therapy services furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.).

(2) PAYMENT.—Payment for such services shall be made at a rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the fee schedule amount provided under section 1848 of the Social Security Act (42 U.S.C. 139w–4) for the same services if such services were furnished by a physician.

(3) APPLICATION OF LIMITS OF BILLING.—The provisions of section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) shall apply to a group weight loss management professional furnishing services under the project in the same manner as they to a practitioner described in subparagraph (C) of such section furnishing services under title XVIII of such Act.

(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project not later than the date that is 6 months after the date on which the project concludes. The final report shall include an evaluation of the impact of the use of group weight loss management services as part of medical nutrition therapy on medicare beneficiaries and on the medicare program, including any impact on reducing costs under the program and improving the health of beneficiaries.

(f) DEFINITIONS.—For purposes of this section:

(1) The term ''obesity'' means that an individual has a Body Mass Index (BMI) of 30 and above.

(2) GROUP WEIGHT LOSS MANAGEMENT SERVICES.—The term ''group weight loss management services'' means comprehensive services furnished to individuals who have been diagnosed and referred by a physician as having impaired glucose tolerance and who are obese that consist of—

(A) assessment and treatment based on the needs of individuals as determined by a group weight loss management professional; or

(B) a specific program or method that has demonstrated its efficacy to produce and maintain weight loss through results published in peer-reviewed scientific journals using recognized research methods and statistical analysis that provides—

(i) assessment of current body weight and recording of weight status at each meeting session;

(ii) provision of a healthy eating plan;

(iii) provision of an activity plan;

(iv) provision of a behavior modification plan; and

(v) a weekly group support meeting.

(3) GROUP WEIGHT LOSS MANAGEMENT PROFESSIONAL.—The term ''group weight loss management professional'' means an individual who has completed training to provide a program or method that has completed clinical trials and has demonstrated its efficacy through publications in peer-reviewed scientific journals who—

(A)(i) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) in nutrition social work, psychology with experience in behavioral modification methods to reduce obesity; or

(ii) has completed a curriculum of training for a specific behavioral based weight management program as described in section (4)(A)(2) and recommended in the NIH Clinical Guidelines on Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, chapter 4, section H, parts 1, 2, 3, 4, and pursuant to guidelines by the Secretary; and

(B)(i) is licensed or certified as a group weight loss management professional by the State in which the services are performed; or

(ii) is certified by an organization that meets such criteria as the Secretary establishes with—

(I) national organizations representing consumers such as the American Obesity Association and the elderly; and

(II) such other organizations as the Secretary determines appropriate.

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms ''hospital'' and ''critical access hospital'' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SEC. 456. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SEC. 457. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

SEC. 458. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

''(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

''(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

''(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).''.

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S. C. 1395fff(b)(5)) is amended by adding at the end the following:''Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

SEC. 459. SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without congressional action, medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007. From 1991 through 2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities, and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts in 2004 and the following years that result from the SGR formula.

On page 542, strike lines 18 through 23, and insert the following:

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term 'review entity' means an entity of up to 3 qualified reviewers drawn from existing appeals levels other than the redetermination level.''.

On page 569, between lines 3 and 4, insert the following:

SEC. 518. REVISIONS TO APPEALS TIMEFRAMES.

Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking ''30-day period'' each place it appears and inserting ''60-day period'';

(2) in subsection (c)(3)(C)(i), by striking ''30-day period'' and inserting ''60-day period'';

(3) in subsection (d)(1)(A), by striking ''90-day period'' and inserting ''120-day period''; and

(4) in subsection (d)(2)(A), by striking ''90-day period'' and inserting ''120-day period''.

SEC. 519. ELIMINATION OF REQUIREMENT TO USE SOCIAL SECURITY ADMINISTRATION ADMINISTRATIVE LAW JUDGES.

The first sentence of section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking ''of the Social Security Administration''.

SEC. 520. ELIMINATION OF REQUIREMENT FOR DE NOVO REVIEW BY THE DEPARTMENTAL APPEALS BOARD.

Section 1869(d)(2) (42 U.S.C. 1395ff(d)(2)) is amended to read as follows:

''(2) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.''.

On page 595, strike lines 1 through 6.

On page 603, after line 25, insert the following:

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).

On page 625, between lines 19 and 20, insert the following:

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services and inpatient hospital services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of enactment of this Act.

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking ''hospice services'' and inserting ''hospice care and post-hospital extended care services''; and

(B) by inserting before the period at the end the following: ''and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management physician services under title XVIII of Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 554. COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395ee), as amended by section 534(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

SEC. 555. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

''(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of enactment of this Act.

On page 629, between lines 17 and 18, insert the following:

(d) URBAN HEALTH PROVIDER ADJUSTMENT.—

(1) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to paragraph (3), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in paragraph (2) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

(2) HOSPITAL DESCRIBED.—A hospital is described in this paragraph if the hospital—

(A) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(B) is located in Marion County, Indiana.

(3) LIMITATION.—The payment adjustment described in paragraph (1) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(1)(A)).

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).''.

On page 676, after line 22, add the following:

SEC. 615. EMPLOYER FLEXIBILITY.

(a) MEDICARE.—Nothing in part D of title XVIII of the Social Security Act, as added by section 101, shall be construed as—

(1) preventing employment-based retiree health coverage (as defined in section 1860D–20(e)(4)(B) of such Act, as so added) from providing coverage that is supplemental to the benefits provided under a Medicare Prescription Drug plan under such part or a MedicareAdvantage plan under part C of such title, as amended by this Act; or

(2) requiring employment-based retiree health coverage (as so defined) that provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act or under a plan maintained by a State or an agency thereof to provide medical benefits, or the same medical benefits, to retired participants who are so eligible.

(b) ADEA.—

(1) IN GENERAL.—Section 4(l) of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 623(l)) is amended by adding at the end the following:

''(4) An employee benefit plan (as defined in section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3))) shall not be treated as violating subsection (a), (b), (c), or (e) solely because the plan provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a plan maintained by a State or an agency thereof, but does not provide medical benefits, or the same medical benefits, to retired participants who are so eligible.''

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply as of the date of the enactment of this Act.

SEC. 616. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting '', and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider'' before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SEC. 617. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking ''until December 31, 2002'', and

(2) by striking ''Kent Community Hospital Complex in Michigan or.''

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SEC. 618. GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G-7 COUNTRIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. The study shall include the following:

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance.

(2) The proportion of the cost for innovation borne by American consumers, compared with consumers in the other 6 countries.

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production (''Ramsey prices'').

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health.

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States.

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied.

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant.

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violations of intellectual property rights for prescription medicines.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).

SEC. 619. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

''PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

''SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

''SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

''(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

''(1) REVIEW.—The Commission shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

''(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

''(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

''(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

''(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

''(E) supporting the development of new data systems where existing data are insufficient or inadequate;

''(F) developing criteria and indicators of impending core health care safety net failure;

''(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

''(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

''(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

''(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

''(ii) the degree to which these plans may be overburdened by adverse selection; and

''(iii) the degree to which emergency departments are used by enrollees of these plans; and

''(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

''(2) REPORTS.—

''(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

''(i) the health care needs of the uninsured; and

''(ii) the financial and infrastructure stability of the Nation's core health care safety net.

''(B) AGENDA AND ADDITIONAL REVIEWS.—

''(i) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

''(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

''(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

''(II) If the Commission deems such additional reviews and reports appropriate.

''(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(3) DEFINITIONS.—In this section:

''(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term 'appropriate committees of Congress' means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

''(B) CORE HEALTH CARE SAFETY NET.—The term 'core health care safety net' means any health care provider that—

''(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

''(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

''(C) HEALTH CARE SAFETY NET PROGRAMS.—The term 'health care safety net programs' includes the following:

''(i) MEDICAID.—The medicaid program under title XIX.

''(ii) SCHIP.—The State children's health insurance program under title XXI.

''(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

''(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(l)(2)(B)) receives funds.

''(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(l)(1)) receives funds.

''(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

''(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

''(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

''(D) VULNERABLE POPULATIONS.—The term 'vulnerable populations' includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the 'Comptroller General'), in consultation with the appropriate committees of Congress.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

''(i) four to serve a term of 1 year;

''(ii) four to serve a term of 2 years; and

''(iii) five to serve a term of 3 years.

''(B) VACANCIES.—

''(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

''(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

''(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

''(4) COMPENSATION.—

''(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

''(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

''(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

''(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

''(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—

''(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

''(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

''(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.''.

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SEC. 620. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—

(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

(A) MEDICARE PROGRAM.—Section 1819(b)(42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:

''(8) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

''(A) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

''(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

''(ii) require, as a condition of employment, that such worker—

''(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

''(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

''(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

''(IV) provide any other identification information the Secretary may specify in regulation;

''(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

''(iv) if that system does not contain any such disqualifying information—

''(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(6); and

''(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

''(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

''(i) IN GENERAL.—A skilled nursing facility may not knowingly employ any skilled nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

''(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a skilled nursing facility may provide for a provisional period of employment for a

skilled nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the covered individual during the worker's provisional period of employment.

''(iii) EXCEPTION FOR SMALL RURAL SKILLED NURSING FACILITIES.—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of skilled nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

''(C) REPORTING REQUIREMENTS.—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

''(D) USE OF INFORMATION.—

''(i) IN GENERAL.—A skilled nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

''(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility that, in denying employment for an individual selected for hiring as a skilled nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

''(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

''(E) CIVIL PENALTY.—

''(i) IN GENERAL.—A skilled nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

''(I) for the first such violation, $2,000; and

''(II) for the second and each subsequent violation within any 5-year period, $5,000.

''(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a skilled nursing facility that—

''(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

''(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

''(F) DEFINITIONS.—In this paragraph:

''(i) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

''(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

''(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

''(ii) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

''(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

''(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

''(II) such other types of acts as the Secretary may specify in regulations.

''(iv) SKILLED NURSING FACILITY WORKER.—The term 'skilled nursing facility worker' means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.''.

(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396r(b)) is amended by adding at the end the following new paragraph:

''(8) SCREENING OF NURSING FACILITY WORKERS.—

''(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a nursing facility selects an individual for a position as a nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

''(i) give the worker written notice that the facility is required to perform background checks with respect to provisional employees;

''(ii) require, as a condition of employment, that such worker—

''(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

''(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

''(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

''(IV) provide any other identification information the Secretary may specify in regulation;

''(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

''(iv) if that system does not contain any such disqualifying information—

''(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(8); and

''(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

''(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

''(i) IN GENERAL.—A nursing facility may not knowingly employ any nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

''(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a nursing facility may provide for a provisional period of employment for a nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the worker during the worker's provisional period of employment.

''(iii) EXCEPTION FOR SMALL RURAL NURSING FACILITIES.—

''(I) IN GENERAL.—In the case of a small rural nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

''(C) REPORTING REQUIREMENTS.—A nursing facility shall report to the State any instance in which the facility determines that a nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

''(D) USE OF INFORMATION.—

''(i) IN GENERAL.—A nursing facility that obtains information about a nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

''(ii) IMMUNITY FROM LIABILITY.—A nursing facility that, in denying employment for an individual selected for hiring as a nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

''(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

''(E) CIVIL PENALTY.—

''(i) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

''(I) for the first such violation, $2,000; and

''(II) for the second and each subsequent violation within any 5-year period, $5,000.

''(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that—

''(I) knowingly continues to employ a nursing facility worker in violation of subparagraph (A) or (B); or

''(II) knowingly fails to report a nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each

subsequent violation within any 5-year period.

''(F) DEFINITIONS.—In this paragraph:

''(i) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

''(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

''(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

''(ii) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

''(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a nursing facility worker has committed—

''(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

''(II) such other types of acts as the Secretary may specify in regulations.

''(iv) NURSING FACILITY WORKER.—The term 'nursing facility worker' means any individual (other than a volunteer) that has access to a patient of a nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.''.

(2) FEDERAL RESPONSIBILITIES.—

(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisional employee at a nursing facility may complete and Federal and State agencies may use to conduct the criminal background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate response to long-term care providers using the system.

(3) NO PREEMPTION OF STRICTER STATE LAWS.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8), 1396r(b)(8)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1128E(g)(6) of the Social Security Act (as added by subsection (e)) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as so defined) to conduct a background check prior to employing an individual in an employment position that is not included in the positions for which a background check is required under such sections.

(4) TECHNICAL AMENDMENTS.—Effective as if included in the enactment of section 941 of BIPA (114 Stat. 2763A–585), sections 1819(b) and 1919(b) (42 U.S.C. 1395i–3(b), 1396r(b)), as amended by such section 941 are each amended by redesignating the paragraph (8) added by such section as paragraph (9).

(b) FEDERAL AND STATE REQUIREMENTS CONCERNING BACKGROUND CHECKS.—

(1) MEDICARE.—Section 1819(e) (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following:

''(6) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

''(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

''(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

''(C) STATE REPORTING OF INFORMATION TO SKILLED NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

''(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

''(ii) immediately report to the skilled nursing facility in writing the results of such review; and

''(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

''(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

''(i) AUTHORITY TO CHARGE FEES.—

''(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation until expended.

''(II) STATE.—A State may charge a skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

''(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

''(E) REGULATIONS.—

''(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(9), including regulations regarding the security confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

''(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

''(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

''(i) the number of requests for searches and exchanges of records made under this section;

''(ii) the disposition of such requests; and

''(iii) the cost of responding to such requests.''.

(2) MEDICAID.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

''(8) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

''(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

''(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

''(C) STATE REPORTING OF INFORMATION TO NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

''(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

''(ii) immediately report to the nursing facility in writing the results of such review; and

''(iii) in the case of an individual with a conviction for a relevant crime, report the

existence of such conviction of such individual to the database established under section 1128E.

''(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

''(i) AUTHORITY TO CHARGE FEES.—

''(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation, until expended.

''(II) STATE.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

''(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

''(E) REGULATIONS.—

''(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

''(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

''(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

''(i) the number of requests for searches and exchanges of records made under this section;

''(ii) the disposition of such requests; and

''(iii) the cost of responding to such requests.''.

(c) APPLICATION TO OTHER ENTITIES PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES.—

(1) MEDICARE.—Part D of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

''APPLICATION OF SKILLED NURSING FACILITY PREVENTIVE ABUSE PROVISIONS TO ANY PROVIDER OF SERVICES OR OTHER ENTITY PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES

''SEC. 1897. (a) IN GENERAL.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a 'medicare beneficiary').

''(b) SUPERVISION OF PROVISIONAL EMPLOYEES.—

''(1) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1819(b)(8)(B)(ii) or 1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

''(2) REQUIREMENTS.—The regulations required under paragraph (1) shall provide the following:

''(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a medicare beneficiary.

''(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

''(i) Follow-up telephone calls to the medicare beneficiary.

''(ii) Unannounced visits to the medicare beneficiary's home while the provisional employee is serving the medicare beneficiary.

''(iii) To the extent practicable, limiting the provisional employee's duties to serving only those medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the medicare beneficiary is present.

''(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such regulations should encourage the provision of monitoring and oversight activities whenever practicable with respect to such an entity, and if such activities would not impose an unreasonable cost or other burden on the entity.''.

(2) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a), as amended by section 104(a), is amended—

(A) in paragraph (65), by striking ''and'' at the end;

(B) in paragraph (66), by striking the period and inserting ''; and''; and

(C) by inserting after paragraph (66) the following:

''(67) provide that any entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services for which medical assistance is available under the State plan to individuals requiring long-term care complies with the requirements of subsections (b)(8) and (e)(8) of section 1919 and section 1897(b) (in the same manner as such section applies to a medicare beneficiary).''.

(3) EXPANSION OF STATE NURSE AIDE REGISTRY.—

(A) MEDICARE.—Section 1819 (42 U.S.C. 1395i–3) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking ''NURSE AIDE REGISTRY'' and inserting ''EMPLOYEE REGISTRY'';

(II) in subparagraph (A)—

(aa) by striking ''By not later than January 1, 1989, the'' and inserting ''The'';

(bb) by striking ''a registry of all individuals'' and inserting ''a registry of (i) all individuals''; and

(cc) by inserting before the period the following: '', (ii) all other skilled nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property''; and

(III) in subparagraph (C), by striking ''a nurse aide'' and inserting ''an individual''; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: ''The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a skilled nursing facility employee of a resident in a skilled nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii).''; and

(II) in the fourth sentence of subparagraph (C), by inserting ''or described in subsection (e)(2)(A)(iii)'' after ''used by the facility''; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking ''NURSE AIDE''; and

(bb) in clause (i), in the matter preceding subclause (I), by striking ''a nurse aide'' and inserting ''an individual''; and

(cc) in clause (i)(I), by striking ''nurse aide'' and inserting ''individual''.

(B) MEDICAID.—Section 1919 (42 U.S.C. 1396r) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking ''NURSE AIDE REGISTRY'' and inserting ''EMPLOYEE REGISTRY'';

(II) in subparagraph (A)—

(aa) by striking ''By not later than January 1, 1989, the'' and inserting ''The'';

(bb) by striking ''a registry of all individuals'' and inserting ''a registry of (i) all individuals''; and

(cc) by inserting before the period the following: '', (ii) all other nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of an entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property''; and

(III) in subparagraph (C), by striking ''a nurse aide'' and inserting ''an individual''; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: ''The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection,

for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility employee of a resident in a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii).''; and

(II) in the fourth sentence of subparagraph (C), by inserting ''or described in subsection (e)(2)(A)(iii)'' after ''used by the facility''; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking ''NURSE AIDE''; and

(bb) in clause (i), in the matter preceding subclause (I), by striking ''a nurse aide'' and inserting ''an individual''; and

(cc) in clause (i)(I), by striking ''nurse aide'' and inserting ''individual''.

(d) REIMBURSEMENT OF COSTS FOR BACKGROUND CHECKS.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1819(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1395i–3(b)(8), 1396r(b)(8)), as added by this section.

(e) INCLUSION OF ABUSIVE ACTS WITHIN A LONG-TERM CARE FACILITY OR PROVIDER IN THE NATIONAL HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.—

(1) IN GENERAL.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a–7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

''(v) A finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient's or resident's property.''.

(2) COVERAGE OF LONG-TERM CARE FACILITY OR PROVIDER EMPLOYEES.—Section 1128E(g)(2) (42 U.S.C. 1320a–7e(g)(2)) is amended by inserting '', and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, providing services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)'' before the period.

(3) REPORTING BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

(A) IN GENERAL.—Section 1128E(b)(1) (42 U.S.C. 1320a–7e(b)(1)) is amended by striking ''and health plan'' and inserting '', health plan, and long-term care facility or provider''.

(B) CORRECTION OF INFORMATION.—Section 1128E(c)(2) (42 U.S.C. 1320a–7e(c)(2)) is amended by striking ''and health plan'' and inserting '', health plan, and long-term care facility or provider''.

(4) ACCESS TO REPORTED INFORMATION.—Section 1128E(d)(1) (42 U.S.C. 1320a–7e(d)(1)) is amended by striking ''and health plans'' and inserting '', health plans, and long-term care facilities or providers''.

(5) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—Section 1128E(d) (42 U.S.C. 1320a–7e(d)) is amended by adding at the end the following:

''(3) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—A long-term care facility or provider shall check the database maintained under this section prior to hiring under an employment or other contract, or both, (other than in a provisional status) any individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, that will provide services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants).''.

(6) DEFINITION OF LONG-TERM CARE FACILITY OR PROVIDER.—Section 1128E(g) (42 U.S.C. 1320a–7e(g)) is amended by adding at the end the following:

''(6) LONG-TERM CARE FACILITY OR PROVIDER.—The term 'long-term care facility or provider' means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(dd)(1)), a long-term care hospital (as described in section 1886(d)(1)(B)(iv)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, home health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program under title XVIII or the medicaid program under title XIX.''.

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the amendments made by this subsection, $10,200,000 for fiscal year 2004.

(f) PREVENTION AND TRAINING DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall be a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to—

(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsman programs, the long-term care industry, and local community members;

(B) examine patient care issues relating to regulatory oversight, community involvement, and facility staffing and management with a focus on staff training, staff stress management, and staff supervision;

(C) examine the use of patient abuse prevention training programs by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used; and

(D) identify and disseminate best practices for preventing and reducing patient abuse.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—With respect to a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) or a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 6 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2006.

(2) LONG-TERM CARE FACILITIES AND PROVIDERS.—With respect to a long-term care facility or provider (as defined in section 1128E(g)(6) of the Social Security Act (42 U.S.C. 1320a–7e(g)(6)) (as added by subsection (e)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 18 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2007.

SEC. 621. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking ''and'' after the comma at the end;

(2) in paragraph (4), by inserting ''and'' after the comma at the end; and

(3) by inserting after paragraph (4) the following new paragraph:

''(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.''.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to conduct a hearing during the session of the Senate on Thursday, June 26, 2003. The purpose of this hearing will be to review H.R. 1904, the Healthy Forests Restoration Act of 2003.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 26, 2003, at 10:00 a.m. to conduct a hearing on ''Affiliate Sharing Practices and Their Relationship with the Fair Credit Reporting Act.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on June 26, 2003, at 9:30 a.m. on pending committee business.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session on Thursday,

June 26, 2003, at 10:00 a.m., to hear testimony on the Nominations of Josette Sheeran Shiner, to Deputy United States Trade Representative, Executive Office of the President and James J. Jochum, to be Assistant Secretary, Department of Commerce.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 26, 2003, at 9:15 a.m. to hold a Business Meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 26, 2003, at 2 p.m. to hold a hearing on The Department of State's Office of Children's Issues—Responding to International Parental Abduction.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Thursday, June 26, 2003, at a time and location to be determined to consider the nominations of Joshua B. Bolten to be Director of the Office of Management and Budget; Fern Flanagan Saddler to be an Associate Judge of the Superior Court of the District of Columbia; and Judith Nan Macaluso to be an Associate Judge of the Superior Court of the District of Columbia.

Agenda

Nominations: Joshua B. Bolten to be Director of the Office of Management and Budget; Fern Flanagan Saddler to be an Associate Judge of the Superior Court for the District of Columbia; and Judith Nan Macaluso to be an Associate Judge of the Superior Court for the District of Columbia.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Thursday, June 26, 2003, at 11 a.m., in room 485 of the Russell Senate Office Building to conduct a business meeting on pending committee matters.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. MCCONNELL. I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on Thursday, June 26, 2003, at 9:30 a.m., in SDG 50.

I. Continuation of S. 1125, Fairness in Asbestos Injury Resolution Act of 2003 (''The FAIR Act'') mark-up.

II. Nominations: William H. Pryor, Jr., to be United States Circuit Judge for the Eleventh Circuit; Diane M. Stuart to be Director, Violence Against Women Office, United States Department of Justice; and Thomas M. Hardiman to be United States District Judge for the Western District of Pennsylvania.

III. Bills: S.J. Res. 1, a joint resolution proposing an amendment to the constitution of the United States to protect the rights of crime victims [Kyl, Chambliss, Cornyn, Craig, DeWine, Feinstein, Graham, Grassley]; S. 1280, a bill to amend the Protect Act to clarify the liability of the National Center for Missing and Exploited Children [Hatch, Biden]; S. 174, a resolution designating Thursday, November 20, 2003, as ''Feed America Thursday'' [Hatch]; and S. 175, a resolution designating the month of October 2003, as ''Family History Month'' [Hatch].

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON TERRORISM, TECHNOLOGY, AND HOMELAND SECURITY

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on Terrorism, Technology, and Homeland Security be authorized to meet to conduct a hearing on ''Terrorism: Growing Wahhabi Influence in the United States'' on Thursday, June 26, 2003 at 2 p.m., in Dirksen 226.

Panel I: David Aufhauser, General Counsel, U.S. Treasury Department, Washington, DC; and Larry A. Mefford, Assistant Director, Counterterrorism Division, Federal Bureau of Investigation, Washington, DC.

Panel 2: Dr. Alex Alexiev, Distinguished Fellow, Center for Security Policy, Washington, DC; and Stephen Schwartz, Senior Fellow, Foundation for Defense of Democracies, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS CONSENT REQUEST—EXECUTIVE CALENDAR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nominations on today's Executive Calendar: Calendar Nos. 48 and 49, the nominations of Daniel Pearson and Charlotte A. Lane, to be members of the U.S. International Trade Commission, which have been pending on the Executive Calendar since March 5. I further ask unanimous consent that the nominations be confirmed, the motions to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDING OFFICER. Is there objection.

Mr. FRIST. Mr. President, on behalf of my colleagues on the other side of the aisle, I object to my own request.

The PRESIDING OFFICER. Objection is heard.

IMPROVING THE EFFICIENCY OF THE NATION'S PAYMENTS SYSTEM

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 168, S. 1334.

The PRESIDING OFFICER. The clerk will state the bill by title.

The legislative clerk read as follows:

A bill (S. 1334) to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. Mr. President, I ask unanimous consent that the bill be read the third time, the Banking Committee be discharged from further consideration of H.R. 1474, and the Senate proceed to its immediate consideration; that all after the enacting clause be stricken and the text of S. 1334 be inserted in lieu thereof; that the bill, as amended, be read the third time and passed; that the motion to reconsider be laid upon the table, and that any statements regarding the measure be printed in the RECORD. I further ask unanimous consent that S. 1334 be returned to the calendar.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 1474), as amended, was passed, as follows:

Resolved, That the bill from the House of Representatives (H.R. 1474) entitled ''An Act to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes.'', do pass with the following amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Check Truncation Act of 2003''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) the Expedited Funds Availability Act (12 U.S.C. 4001 et seq.)—

(A) directs the Board to consider establishing regulations requiring Federal reserve banks and

depository institutions to provide for check truncation, in order to improve the check processing system;

(B) authorizes the Board to regulate all aspects of the payment system, including the receipt, payment, collection, and clearing of checks, and related functions of the payment system pertaining to checks; and

(C) directs that the exercise of such authority by the Board shall supersede any State law, including the Uniform Commercial Code, as in effect in any State; and

(2) check truncation is no less desirable in 2003 for both financial service customers and the financial services industry, to reduce costs, improve efficiency in check collections, and expedite funds availability for account holders than it was in 1987, when Congress first directed the Board to consider establishing such a process.

(b) PURPOSES.—The purposes of this Act are—

(1) to facilitate check truncation by authorizing substitute checks;

(2) to foster innovation in the check collection system without mandating receipt of checks in electronic form; and

(3) to improve the overall efficiency of the Nation's payments system.

SEC. 3. DEFINITIONS.

In this Act, the following definitions shall apply:

(1) ACCOUNT.—The term ''account'' means a deposit account at a bank.

(2) BANK.—The term ''bank''—

(A) means any person located in a State engaged in the business of banking, including any depository institution; and

(B) includes—

(i) any Federal reserve bank;

(ii) any Federal home loan bank; and

(iii) to the extent that it acts as a payor—

(I) the Treasury of the United States;

(II) the United States Postal Service;

(III) a State government; and

(IV) a unit of general local government.

(3) BANKING TERMS.—

(A) COLLECTING BANK.—The term ''collecting bank'' means any bank handling a check for collection except the paying bank.

(B) DEPOSITARY BANK.—The term ''depositary bank'' means—

(i) the first bank to which a check is transferred, even if such bank is also the paying bank or the payee; or

(ii) a bank to which a check is transferred for deposit in an account at such bank, even if the check is physically received and endorsed first by another bank.

(C) DEPOSITORY INSTITUTION.—The term ''depository institution'' has the same meaning as in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A)).

(D) PAYING BANK.—The term ''paying bank'' means—

(i) the bank by which a check is payable, unless the check is payable at or through another bank and is sent to the other bank for payment or collection; or

(ii) the bank at or through which a check is payable and to which the check is sent for payment or collection.

(E) RETURNING BANK.—

(i) IN GENERAL.—The term ''returning bank'' means a bank (other than the paying or depositary bank) handling a returned check or notice in lieu of return.

(ii) TREATMENT AS COLLECTING BANK.—No provision of this Act shall be construed as affecting the treatment of a returning bank as a collecting bank for purposes of section 4–202(b) of the Uniform Commercial Code.

(4) BOARD.—The term ''Board'' means the Board of Governors of the Federal Reserve System.

(5) BUSINESS DAY.—The term ''business day'' has the same meaning as in section 602(3) of the Expedited Funds Availability Act (12 U.S.C. 4001(3)).

(6) CHECK.—The term ''check''—

(A) means a draft, payable on demand and drawn on or payable through or at an office of a bank, whether or not negotiable, that is handled for forward collection or return, including a substitute check and a travelers check; and

(B) does not include a noncash item or an item payable in a medium other than United States dollars.

(7) CONSUMER.—The term ''consumer'' means an individual who—

(A) with respect to a check handled for forward collection, draws the check on a consumer account; or

(B) with respect to a check handled for return, deposits the check into, or cashes the check against, a consumer account.

(8) CONSUMER ACCOUNT.—The term ''consumer account'' has the same meaning as in section 602(10) of the Expedited Funds Availability Act (12 U.S.C. 4001(10)).

(9) CUSTOMER.—The term ''customer'' means a person having an account with a bank.

(10) FORWARD COLLECTION.—The term ''forward collection'' means the transfer by a bank of a check to a collecting bank for settlement or the paying bank for payment.

(11) INDEMNIFYING BANK.—The term ''indemnifying bank'' means a bank that is providing an indemnity under section 6 with respect to a substitute check.

(12) MICR LINE.—The term ''MICR line'' or ''magnetic ink character recognition line'' means the numbers, which may include the bank routing number, account number, check number, check amount, and other information, that are printed near the bottom of a check in magnetic ink in accordance with generally applicable industry standards.

(13) NONCASH ITEM.—The term ''noncash item'' has the same meaning as in section 602(14) of the Expedited Funds Availability Act (12 U.S.C. 4001(14)).

(14) PERSON.—The term ''person'' means a natural person, corporation, unincorporated company, partnership, government unit or instrumentality, trust, or any other entity or organization.

(15) RECONVERTING BANK.—The term ''reconverting bank'' means—

(A) the bank that creates a substitute check; or

(B) if a substitute check is created by a person other than a bank, the first bank that transfers or presents such substitute check.

(16) SUBSTITUTE CHECK.—The term ''substitute check'' means a paper reproduction of the original check that—

(A) contains an image of the front and back of the original check;

(B) bears a MICR line containing all the information appearing on the MICR line of the original check, except as provided under generally applicable industry standards for substitute checks to facilitate the processing of substitute checks;

(C) conforms, in paper stock, dimension, and otherwise, with generally applicable industry standards for substitute checks; and

(D) is suitable for automated processing in the same manner as the original check.

(17) STATE.—The term ''State'' has the same meaning as in section 3(a) of the Federal Deposit Insurance Act (12 U.S.C. 1813(a)).

(18) TRUNCATE.—The term ''truncate'' means to remove an original paper check from the check collection or return process and send to a recipient, in lieu of such original paper check, a substitute check or, by agreement, information relating to the original check (including data taken from the MICR line of the original check or an electronic image of the original check), whether with or without subsequent delivery of the original paper check.

(19) UNIFORM COMMERCIAL CODE.—The term ''Uniform Commercial Code'' means the Uniform Commercial Code in effect in a State.

(20) UNIT OF GENERAL LOCAL GOVERNMENT.—The term ''unit of general local government'' has the same meaning as in section 602(24) of the Expedited Funds Availability Act (12 U.S.C. 4001(24)).

(21) OTHER TERMS.—Unless the context requires otherwise, terms used in this Act that are not defined in this section shall have the same meanings as in the Uniform Commercial Code.

SEC. 4. GENERAL PROVISIONS GOVERNING SUBSTITUTE CHECKS.

(a) NO AGREEMENT REQUIRED.—A person may deposit, present, or send for collection or return a substitute check without an agreement with the recipient, to the extent that the bank has made the warranties described in section 5 with respect to the substitute check.

(b) LEGAL EQUIVALENCE.—A substitute check shall be the legal equivalent of an original check for all purposes, including any provision of any Federal or State law, and for all persons, if the substitute check—

(1) accurately represents all of the information on the front and back of the original check as of the time at which the original check was truncated; and

(2) bears the legend: ''This is a legal copy of your check. You can use it the same way you would use the original check.''.

(c) ENDORSEMENTS.—A reconverting bank shall ensure that the substitute check for which the bank is the reconverting bank bears all endorsements applied by parties that previously handled the check (whether in electronic form or in the form of the original paper check or a substitute check) for forward collection or return.

(d) IDENTIFICATION OF RECONVERTING BANK.—A reconverting bank shall identify itself as a reconverting bank on any substitute check for which the bank is a reconverting bank, so as to preserve any previous reconverting bank identifications, in conformance with generally applicable industry standards.

(e) APPLICABLE LAW.—A substitute check that is the legal equivalent of the original check under subsection (b) shall be subject to any provision, including any provision relating to the protection of consumers, of part 229 of title 12, Code of Federal Regulations (or any successor thereto), the Uniform Commercial Code, and any other applicable Federal or State law that would apply if the substitute check were the original check, to the extent that such provision of law is not inconsistent with this Act.

SEC. 5. SUBSTITUTE CHECK WARRANTIES.

A bank that transfers, presents, or returns a substitute check and receives consideration for the check warrants to the transferee, any subsequent collecting or returning bank, the depositary bank, the drawee, the drawer, the payee, the depositor, and any endorser (regardless of whether the warrantee receives the substitute check or another paper or electronic form of the substitute or original check) that—

(1) the substitute check meets all the requirements for legal equivalence under section 4(b); and

(2) no depositary bank, drawee, drawer, or endorser will receive presentment or return of the substitute check, the original check, or a copy or other paper or electronic version of the substitute check or original check such that it will be asked to make a payment based on a check it has already paid.

SEC. 6. INDEMNITY.

(a) INDEMNITY.—A reconverting bank and each bank that subsequently transfers, presents, or returns a substitute check in any electronic or paper form, and receives consideration for such transfer, presentment, or return shall indemnify the transferee, any subsequent collecting or returning bank, the depositary bank, the drawee, the drawer, the payee, the depositor, and any endorser, up to the amounts described in subsections (b) and (c), as applicable, to the extent of any loss incurred by any recipient of a substitute check if that loss occurred due to the receipt of a substitute check instead of the original check.

(b) INDEMNITY AMOUNT.—

(1) AMOUNT IN EVENT OF BREACH OF WARRANTY.—The amount of the indemnity under subsection (a) shall be the amount of any loss (including costs and reasonable attorney fees and other expenses of representation) proximately caused by a breach of a warranty established under section 5.

(2) AMOUNT IN ABSENCE OF BREACH OF WARRANTY.—In the absence of a breach of a warranty established under section 5, the amount of the indemnity under subsection (a) shall be the sum of—

(A) the amount of any loss, up to the amount of the substitute check; and

(B) interest and expenses (including costs and reasonable attorney fees and other expenses of representation).

(c) COMPARATIVE NEGLIGENCE.—

(1) IN GENERAL.—If a loss under subsection (a) results in whole or in part from the negligence or failure to act in good faith on the part of an indemnified party, then the indemnification of that party under this section shall be reduced in proportion to the amount of negligence or bad faith attributable to that party.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection reduces the rights of a consumer or any other person under the Uniform Commercial Code or other applicable provision of Federal or State law.

(d) EFFECT OF PRODUCING ORIGINAL CHECK OR SUBSTITUTE CHECK.—

(1) IN GENERAL.—If the indemnifying bank produces the original check or a copy of the original check (including an image or a substitute check) that accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated), or is otherwise sufficient to determine whether or not a claim is valid, the indemnifying bank shall—

(A) be liable under this section only for losses covered by the indemnity that are incurred up to the time that the original check or copy is provided to the indemnified party; and

(B) have a right to the return of any funds it has paid under the indemnity in excess of those losses.

(2) COORDINATION OF INDEMNITY WITH IMPLIED WARRANTY.—The production of the original check, substitute check, or copy under paragraph (1) by an indemnifying bank shall not absolve the bank from any liability on a warranty established under this Act or any other provision of law.

(e) SUBROGATION OF RIGHTS.—

(1) IN GENERAL.—Each indemnifying bank shall be subrogated to the rights of any indemnified party to the extent of the indemnity.

(2) RECOVERY UNDER WARRANTY.—A bank that indemnifies a party under this section may attempt to recover from another party based on a warranty or other claim.

(3) DUTY OF INDEMNIFIED PARTY.—Each indemnified party shall have a duty to comply with all reasonable requests for assistance from an indemnifying bank in connection with any claim that the indemnifying bank brings against a warrantor or other party related to a check that forms the basis for the indemnification.

SEC. 7. EXPEDITED RECREDIT FOR CONSUMERS.

(a) RECREDIT CLAIMS.—

(1) IN GENERAL.—A consumer may make a claim for expedited recredit from the bank that holds the account of the consumer with respect to a substitute check, if the consumer asserts in good faith that—

(A) the bank charged the consumer account for a substitute check that was provided to the consumer;

(B) either—

(i) the check was not properly charged to the consumer account; or

(ii) the consumer has a warranty claim with respect to such substitute check;

(C) the consumer suffered a resulting loss; and

(D) the production of the original check or a better copy of the original check is necessary to determine the validity of any claim described in subparagraph (B).

(2) 40-DAY PERIOD.—Any claim under paragraph (1) with respect to a consumer account may be submitted by a consumer before the end of the 40-day period beginning on the later of—

(A) the date on which the financial institution mails or delivers, by a means agreed to by the consumer, the periodic statement of account for such account which contains information concerning the transaction giving rise to the claim; or

(B) the date on which the substitute check is made available to the consumer.

(3) EXTENSION UNDER EXTENUATING CIRCUMSTANCES.—If the ability of the consumer to submit the claim within the 40-day period under paragraph (2) is delayed due to extenuating circumstances, including extended travel or the illness of the consumer, the 40-day period shall be extended by a reasonable amount of time.

(b) PROCEDURES FOR CLAIMS.—

(1) IN GENERAL.—To make a claim for an expedited recredit under subsection (a) with respect to a substitute check, the consumer shall provide to the bank that holds the account of such consumer—

(A) a description of the claim, including an explanation of—

(i) why the substitute check was not properly charged to the subject consumer account; or

(ii) the warranty claim with respect to such check;

(B) a statement that the consumer suffered a loss and an estimate of the amount of the loss;

(C) the reason why production of the original check or a better copy of the original check is necessary to determine the validity of the charge to the subject consumer account or the warranty claim; and

(D) sufficient information to identify the substitute check and to investigate the claim.

(2) CLAIM IN WRITING.—

(A) IN GENERAL.—The bank holding the consumer account that is the subject of a claim by the consumer under subsection (a) may, in the discretion of the bank, require the consumer to submit the information required under paragraph (1) in writing.

(B) MEANS OF SUBMISSION.—A bank that requires a submission of information under subparagraph (A) may permit the consumer to make the submission electronically, if the consumer has agreed to communicate with the bank in that manner.

(c) RECREDIT TO CONSUMER.—

(1) CONDITIONS FOR RECREDIT.—The bank shall recredit a consumer account in accordance with paragraph (2) for the amount of a substitute check that was charged against the consumer account, if—

(A) a consumer submits a claim to the bank with respect to that substitute check that meets the requirement of subsection (b); and

(B) the bank has not—

(i) provided to the consumer—

(I) the original check; or

(II) a copy of the original check (including an image or a substitute check) that accurately represents all of the information on the front and back of the original check, as of the time at which the original check was truncated; and

(ii) demonstrated to the consumer that the substitute check was properly charged to the consumer account.

(2) TIMING OF RECREDIT.—

(A) IN GENERAL.—The bank shall recredit the subject consumer account for the amount described in paragraph (1) not later than the end of the business day following the business day on which the bank determines the claim of the consumer is valid.

(B) RECREDIT PENDING INVESTIGATION.—If the bank has not determined that the claim of the consumer is valid before the end of the 10th business day after the business day on which the consumer submitted the claim, the bank shall recredit the subject consumer account for—

(i) the lesser of the amount of the substitute check that was charged against the consumer account, or $2,500, together with interest if the account is an interest-bearing account, not later than the end of such 10th business day; and

(ii) the remaining amount of the substitute check that was charged against the consumer account, if any, together with interest if the account is an interest-bearing account, not later than the 45th calendar day following the business day on which the consumer submits the claim.

(d) AVAILABILITY OF RECREDIT.—

(1) NEXT BUSINESS DAY AVAILABILITY.—Except as provided in paragraph (2), a bank that provides a recredit to a consumer account under subsection (c) shall make the recredited funds available for withdrawal by the consumer by the start of the next business day after the business day on which the bank recredits the consumer account under subsection (c).

(2) SAFEGUARD EXCEPTIONS.—A bank may delay availability to a consumer of a recredit provided under subsection (c)(2)(B)(i) until the start of either the business day following the business day on which the bank determines that the claim of the consumer is valid, or the 45th calendar day following the business day on which the consumer submits a claim for such recredit in accordance with subsection (b), whichever is earlier, in any of the following circumstances:

(A) NEW ACCOUNTS.—The claim is made during the 30-day period beginning on the business day on which the consumer account was established.

(B) REPEATED OVERDRAFTS.—Without regard to the charge that is the subject of the claim for which the recredit was made—

(i) on 6 or more business days during the 6-month period ending on the date on which the consumer submits the claim, the balance in the consumer account was negative or would have become negative if checks or other charges to the account had been paid; or

(ii) on 2 or more business days during such 6-month period, the balance in the consumer account was negative or would have become negative in the amount of $5,000 or more if checks or other charges to the account had been paid.

(C) PREVENTION OF FRAUD LOSSES.—The bank has reasonable cause to believe that the claim is fraudulent, based on facts (other than the fact that the check in question or the consumer is of a particular class) that would cause a well-grounded belief in the mind of a reasonable person that the claim is fraudulent.

(3) OVERDRAFT FEES.—No bank that, in accordance with paragraph (2), delays the availability of a recredit under subsection (c) to any consumer account may impose any overdraft fees with respect to drafts drawn by the consumer on such recredited amount before the end of the 5-day period beginning on the date on which notice of the delay in the availability of such amount is sent by the bank to the consumer.

(e) REVERSAL OF RECREDIT.—A bank may reverse a recredit to a consumer account if the bank—

(1) determines that a substitute check for which the bank recredited a consumer account under subsection (c) was in fact properly charged to the consumer account; and

(2) notifies the consumer in accordance with subsection (f)(3).

(f) NOTICE TO CONSUMER.—

(1) NOTICE IF CONSUMER CLAIM NOT VALID.—If a bank determines that a substitute check subject to the claim of a consumer under this section was in fact properly charged to the consumer account, the bank shall send to the consumer, not later than the business day following the business day on which the bank makes the determination—

(A) the original check or a copy of the original check (including an image or a substitute check) that—

(i) accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated); or

(ii) is otherwise sufficient to determine whether or not the claim of the consumer is valid; and

(B) an explanation of the basis for the determination by the bank that the substitute check was properly charged, including a statement that the consumer may request copies of any information or documents on which the bank relied in making the determination.

(2) NOTICE OF RECREDIT.—If a bank recredits a consumer account under subsection (c), the bank shall send to the consumer, not later than the business day following the business day on which the bank makes the recredit, a notice of—

(A) the amount of the recredit; and

(B) the date on which the recredited funds will be available for withdrawal.

(3) NOTICE OF REVERSAL OF RECREDIT.—In addition to the notice required under paragraph (1), if a bank reverses a recredited amount under subsection (e), the bank shall send to the consumer, not later than the business day following the business day on which the bank reverses the recredit, a notice of—

(A) the amount of the reversal; and

(B) the date on which the recredit was reversed.

(4) MODE OF DELIVERY.—A notice described in this subsection shall be delivered by United States mail or by any other means through which the consumer has agreed to receive account information.

(g) OTHER CLAIMS NOT AFFECTED.—Providing a recredit in accordance with this section shall not absolve the bank from liability for a claim made under any other provision of law, such as a claim for wrongful dishonor under the Uniform Commercial Code, or from liability for additional damages under section 6 or 10.

(h) SCOPE OF APPLICATION.—This section shall only apply to customers who are consumers.

SEC. 8. EXPEDITED RECREDIT PROCEDURES FOR BANKS.

(a) RECREDIT CLAIMS.—

(1) IN GENERAL.—A bank may make a claim against an indemnifying bank for expedited recredit for which that bank is indemnified, if—

(A) the claimant bank (or a bank that the claimant bank has indemnified) has received a claim for expedited recredit from a consumer under section 7 with respect to a substitute check, or would have been subject to such a claim had the subject consumer account been charged;

(B) the claimant bank has suffered a resulting loss or is obligated to recredit the consumer account under section 7 with respect to such substitute check; and

(C) production of the original check or a better copy of the original check is necessary to determine the validity of the charge to the consumer account or any warranty claim connected with such substitute check.

(2) 120-DAY PERIOD.—Any claim under paragraph (1) may be submitted by the claimant bank to an indemnifying bank before the end of the 120-day period beginning on the date of the transaction that gave rise to the claim.

(b) PROCEDURES FOR CLAIMS.—

(1) IN GENERAL.—To make a claim under subsection (a) for an expedited recredit relating to a substitute check, the claimant bank shall send to the indemnifying bank—

(A) a description of—

(i) the claim, including an explanation of why the substitute check cannot be properly charged to the consumer account; or

(ii) the warranty claim;

(B) a statement that the claimant bank has suffered a loss or is obligated to recredit the subject consumer account under section 7, together with an estimate of the amount of the loss or recredit;

(C) the reason why production of the original check or a better copy of the original check is necessary to determine the validity of the charge to the consumer account or the warranty claim; and

(D) information sufficient for the indemnifying bank to identify the substitute check and to investigate the claim.

(2) REQUIREMENTS RELATING TO COPIES OF SUBSTITUTE CHECKS.—If the information submitted by a claimant bank pursuant to paragraph (1) in connection with a claim for an expedited recredit includes a copy of any substitute check for which any such claim is made, the claimant bank shall take reasonable steps to ensure that any such copy cannot be—

(A) mistaken for the legal equivalent of the check under section 4(b); or

(B) sent or handled by any bank, including the indemnifying bank, as a forward collection or returned check.

(3) CLAIM IN WRITING.—

(A) IN GENERAL.—An indemnifying bank may, in the discretion of the bank, require the claimant bank to submit the information required by paragraph (1) in writing, including a copy of the written or electronically submitted claim, if any, that the consumer provided in accordance with section 7(b).

(B) MEANS OF SUBMISSION.—An indemnifying bank that requires a submission of information under subparagraph (A) may permit the claimant bank to make the submission electronically, if the claimant bank has agreed to communicate with the indemnifying bank in that manner.

(c) RECREDIT BY INDEMNIFYING BANK.—

(1) PROMPT ACTION REQUIRED.—Not later than 10 business days after the business day on which an indemnifying bank receives a claim under subsection (a) from a claimant bank with respect to a substitute check, the indemnifying bank shall—

(A) provide, to the claimant bank, the original check (with respect to such substitute check) or a copy of the original check (including an image or a substitute check) that—

(i) accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated); or

(ii) is otherwise sufficient to determine that the claim of the bank is not valid;

(B) recredit the claimant bank for the amount of the claim up to the amount of the substitute check, plus interest if applicable; or

(C) provide information to the claimant bank as to why the indemnifying bank is not obligated to comply with subparagraph (A) or (B).

(2) RECREDIT DOES NOT ABROGATE OTHER LIABILITIES.—Providing a recredit under this subsection to a claimant bank with respect to a substitute check shall not absolve the indemnifying bank from liability for claims brought under any other law or from additional damages under section 6 or 10 with respect to such check.

(3) REFUND TO INDEMNIFYING BANK.—If a claimant bank reverses, in accordance with section 7(e), a recredit previously made to a consumer account under section 7(c), or otherwise receives a credit or recredit with regard to such substitute check, the claimant bank shall promptly refund to any indemnifying bank any amount previously advanced by the indemnifying bank in connection with such substitute check.

(d) PRODUCTION OF ORIGINAL CHECK OR A SUFFICIENT COPY GOVERNED BY SECTION 6(d).—If the indemnifying bank provides the claimant bank with the original check or a copy of the original check (including an image or a substitute check) under subsection (c)(1)(A) of this section, section 6(d) shall govern any right of the indemnifying bank to any repayment of any funds that the indemnifying bank has recredited to the claimant bank pursuant to subsection (c).

SEC. 9. DELAYS IN AN EMERGENCY.

Delay by a bank beyond the time limits prescribed or permitted by this Act is excused if the delay is caused by interruption of communication or computer facilities, suspension of payments by another bank, war, emergency conditions, failure of equipment, or other circumstances beyond the control of a bank, and if the bank uses such diligence as the circumstances require.

SEC. 10. MEASURE OF DAMAGES.

(a) LIABILITY.—

(1) IN GENERAL.—Except as provided in section 6, any person who, in connection with a substitute check, breaches any warranty under this Act or fails to comply with any requirement imposed by or regulation prescribed pursuant to this Act with respect to any other person shall be liable to such person in an amount equal to the sum of—

(A) the lesser of—

(i) the amount of the loss suffered by the other person as a result of the breach or failure; or

(ii) the amount of the substitute check; and

(B) interest and expenses (including costs and reasonable attorney fees and other expenses of representation) related to the substitute check.

(2) OFFSET OF RECREDITS.—The amount of damages that any person receives under paragraph (1), if any, shall be reduced by the amount that the claimant receives and retains as a recredit under section 7 or 8, if any.

(b) COMPARATIVE NEGLIGENCE.—

(1) IN GENERAL.—If a person incurs damages that resulted in whole or in part from the negligence or failure of that person to act in good faith, then the amount of any liability due to that person under subsection (a) shall be reduced in proportion to the amount of negligence or bad faith attributable to that person.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection reduces the rights of a consumer or any other person under the Uniform Commercial Code or other applicable provision of Federal or State law.

SEC. 11. STATUTE OF LIMITATIONS AND NOTICE OF CLAIM.

(a) ACTIONS UNDER THIS ACT.—

(1) IN GENERAL.—An action to enforce a claim under this Act may be brought in any United States district court, or in any other court of competent jurisdiction, before the end of the 1-year period beginning on the date on which the cause of action accrues.

(2) ACCRUAL.—For purposes of paragraph (1), a cause of action accrues as of the date on which the injured party first learns, or by which such person reasonably should have learned, of the facts and circumstances giving rise to the cause of action.

(b) NOTICE OF CLAIMS REQUIRED.—Unless a person gives notice of a claim to the indemnifying or warranting bank, not later than 30 days after the person has reason to know of the claim and the identity of the indemnifying or warranting bank, the indemnifying or warranting bank is discharged from liability in an action to enforce a claim under this Act, to the extent of any loss caused by the delay in giving notice of the claim.

(c) NOTICE OF CLAIM BY CONSUMER.—A timely claim by a consumer under section 7 for expedited recredit constitutes timely notice of a claim by the consumer for purposes of subsection (b).

SEC. 12. CONSUMER AWARENESS.

(a) IN GENERAL.—During the 3-year period beginning on the effective date of this Act, each bank shall provide to each consumer that is a customer of the bank, in accordance with subsection (b), a brief notice about substitute checks that describes—

(1) how a substitute check is the legal equivalent of an original check for all purposes, including any provision of any Federal or State law, and for all persons, if the substitute check—

(A) accurately represents all of the information on the front and back of the original check

as of the time at which the original check was truncated; and

(B) bears the legend: ''This is a legal copy of your check. You can use it in the same way you would use the original check.''; and

(2) the consumer recredit rights established under section 7 when a consumer believes in good faith that a substitute check was not properly charged to the account of the consumer.

(b) DISTRIBUTION.—

(1) IN GENERAL.—The notice required by subsection (a) shall be provided—

(A) to each consumer that is a customer of the bank as of the effective date of this Act, and that receives original checks or substitute checks along with periodic account statements, not later than together with the first regularly scheduled communication with the customer after the effective date of this Act;

(B) at the time at which a customer relationship is initiated, if such relationship is initiated on or after the effective date of this Act and such customer will receive original checks or substitute checks along with periodic account statements; and

(C) to each customer of the bank that requests a copy of a check and receives a substitute check, at the time of the request.

(2) MODE OF DELIVERY.—A bank may provide the notices required by this subsection by United States mail, or by any other means through which the consumer has agreed to receive account information.

(c) MODEL LANGUAGE.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Board shall publish model forms and clauses that a depository institution may use to describe each of the elements required by subsection (a).

(2) SAFE HARBOR.—A bank shall be treated as being in compliance with the requirements of subsection (a) if the substitute check notice of the bank uses a model form or clause published by the Board, and such model form or clause accurately describes the policies and practices of the bank. A bank may delete any information in the model form or clause that is not required by this Act, or rearrange the format of such form.

(3) USE OF MODEL LANGUAGE NOT REQUIRED.—This section shall not be construed as requiring any bank to use a model form or clause that the Board prepares under this subsection.

SEC. 13. EFFECT ON OTHER LAW.

This Act shall supersede any provision of Federal or State law, including the Uniform Commercial Code, that is inconsistent with this Act, but only to the extent of the inconsistency.

SEC. 14. REGULATIONS.

The Board may prescribe such regulations as it deems necessary to implement, prevent circumvention or evasion of, or facilitate compliance with the provisions of this Act.

SEC. 15. STUDY AND REPORT ON FUNDS AVAILABILITY.

(a) STUDY.—In order to evaluate the implementation and the impact of this Act, the Board shall conduct a study of—

(1) the percentage of total checks cleared in which the paper check is not returned to the paying bank;

(2) the extent to which financial institutions make funds available to consumers for local and nonlocal checks prior to the expiration of maximum hold periods;

(3) the length of time within which depositary banks learn of the nonpayment of local and nonlocal checks;

(4) the increase or decrease in check-related losses over the study period; and

(5) the appropriateness of the time periods and amount limits applicable under sections 603 and 604 of the Expedited Funds Availability Act, as in effect on the date of enactment of this Act.

(b) REPORT TO CONGRESS.—Not later than 30 months after the effective date of this Act, the Board shall submit a report to Congress concerning the results of the study conducted under this section, together with any recommendations for legislative action.

SEC. 16. EVALUATION AND REPORT BY THE COMPTROLLER GENERAL.

(a) STUDY.—Not later than 5 years after the date of enactment of this Act, the Comptroller General of the United States shall evaluate the implementation and administration of this Act, including—

(1) an estimate of the gains in economic efficiency made possible from check truncation;

(2) an evaluation of the benefits accruing to consumers and financial institutions from reduced transportation costs, longer hours for accepting deposits for credit within 1 business day, the impact of fraud losses, and an estimate of consumers' share of the total benefits derived from this Act; and

(3) an assessment of consumer acceptance of the check truncation process resulting from this Act, as well as any new costs incurred by consumers who had their original checks returned with their regular monthly statements prior to the date of enactment of this Act.

(b) REPORT TO CONGRESS.—Not later than 5 years after the date of enactment of this Act, the Comptroller General shall submit a report to Congress concerning the findings and conclusions of the Comptroller General in connection with the evaluation conducted pursuant to subsection (a), together with such recommendations for legislative and administrative action as the Comptroller General may determine to be appropriate.

SEC. 17. VARIATION BY AGREEMENT.

(a) SECTION 8.—Any provision of section 8 may be varied by agreement of the banks involved.

(b) NO OTHER PROVISIONS MAY BE VARIED.—Except as provided in subsection (a), no provision of this Act may be varied by agreement of any person or persons.

SEC. 18. EFFECTIVE DATE.

Except as otherwise specifically provided in this Act, this Act shall become effective 12 months after the date of enactment of this Act.

COMMENDING AUGUST HIEBERT

EXPRESSING SENSE OF THE SENATE REGARDING THE CENTENARY OF THE RHODES SCHOLARSHIPS IN THE UNITED STATES

HONORING MAYNARD HOLBROOK JACKSON, JR.

COMMENDING GENERAL ERIC SHINSEKI

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of the following Senate resolutions, en bloc: S. Res. 186, S. Res. 187, S. Res. 188, and S. Res. 190.

The PRESIDING OFFICER. The clerk will report the resolutions by title.

The legislative clerk read as follows:

A resolution (S. Res. 186) commending August Hiebert for his Service to the Alaska Communications Industry.

A resolution (S. Res. 187) expressing the sense of the Senate regarding the centenary of the Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation.

A resolution (S. Res. 188) honoring Maynard Holbrooke Jackson, Jr., former Mayor of the City of Atlanta, and extending condolences of the Senate on his death.

A resolution (S. Res. 190) commending General Eric Shinseki of the United States Army for his outstanding service and commitment to excellence.

There being no objection, the Senate proceeded to consider the resolutions, en bloc.

Mr. FRIST. Mr. President, I ask unanimous consent that the resolutions be agreed to, en bloc; that the preambles be agreed to, en bloc; that the motions to reconsider be laid upon the table; and that any statements relating to these resolutions be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 186) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 186

Whereas Augie Hiebert came to Alaska in 1939 and built the first successful commercial radio station;

Whereas on Dec. 7, 1941, Augie Hiebert picked up the first report of the raid on Pearl Harbor from his radio station in Fairbanks, Alaska giving military leaders the first word of the attack that began World War II;

Whereas in 1953, Augie Hiebert founded Alaska's first television station;

Whereas Augie Hiebert established Alaska's first FM radio station and was named president of the Alaska Broadcasting system, overseeing the affiliation of nine stations that serve all major Alaska communities;

Whereas Augie Hiebert helped establish Alaska's first satellite earth station activated in 1970;

Whereas Augie Hiebert led in the development of the Territory and State of Alaska, working for over a half century to pioneer modern radio and television on behalf of the broadcast industry;

Whereas Augie Hiebert has been a pillar of the Alaska community as president of the Anchorage Chamber of Commerce and the Association of the U.S. Army in Alaska, and as director of the Alaska Educational Broadcasting Committee, the CBS Television Network Affiliates Association, the Civil Air Patrol, and the Pioneers of Alaska: Now, therefore, be it

Resolved, That it is the sense of the Senate that Augie Hiebert is commended for his service to the communications industry in Alaska and the world and for bringing the best that broadcasting has to offer to the people of Alaska.

The resolution (S. Res. 187) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 187

Whereas the Rhodes Scholarships, the oldest international fellowships, were initiated after the death of Cecil Rhodes in 1902, and now bring outstanding students from the United States, Australia, Bangladesh, Bermuda, Canada, the Commonwealth Caribbean, Germany, Hong Kong, India, Jamaica, Kenya, Malaysia, New Zealand, Pakistan, Singapore, South Africa, Uganda, Zambia, and Zimbabwe to the University of Oxford;

Whereas the first American Rhodes Scholars were elected in 1904, and since that time

distinguished American Rhodes alumni have included over 20 members of Congress, a President of the United States, 3 Supreme Court justices, cabinet members, military leaders, 80 heads of colleges or universities, and prominent artists, scientists, and business people;

Whereas the Mandela Rhodes Foundation, a partnership between the Rhodes Trust and the Nelson Mandela Foundation, was established in February, 2002;

Whereas after a lifetime of struggle against apartheid and the momentous challenge of governing the new South Africa as its first democratically elected President, Nobel Peace Prize Laureate Nelson Rolihlahla Mandela continues to be devoted to building a society characterized by justice and opportunity in the Republic of South Africa;

Whereas President Mandela's efforts have manifested themselves in the work of the Nelson Mandela Children's Fund, established in the wake of President Mandela's pledge to devote ⅓ of his Presidential salary to projects aimed at improving the quality of life of South Africa's disadvantaged children; and

Whereas in Cape Town in February, 2002, President Mandela noted that the partnership between the Rhodes Trust and the new Mandela Foundation signals ''the closing of the circle and the coming together of 2 strands in our history'': Now, therefore, be it

Resolved, That the Senate—

(1) celebrates the centenary of the Rhodes Scholarships in the United States;

(2) welcomes the establishment of the Mandela Rhodes Foundation, which embodies the spirit of reconciliation and shared commitment that is one of South Africa's greatest assets;

(3) shares the Foundation's commitment to support initiatives aimed at increasing educational opportunities, fostering leadership, and promoting human resource development throughout Africa; and

(4) affirms the support of the United States for these worthy goals throughout the sub-Saharan region, and asserts that the pursuit of these goals is in the shared interest of the American and African people.

The resolution (S. Res. 188) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 188

Whereas the Honorable Maynard Holbrook Jackson, Jr. was born on March 23, 1938, in Dallas, Texas, and at the age of 14 entered Morehouse College as a Ford Foundation Early Admission Scholar;

Whereas the Honorable Maynard Holbrook Jackson, Jr. graduated *cum laude* from North Carolina Central University School of Law;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became the first African–American Vice Mayor of the City of Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. proved to be a gifted and brilliant political leader, and he later became the first African–American Mayor of the City of Atlanta;

Whereas, during his years in office, the Honorable Maynard Holbrook Jackson, Jr. was the catalyst for the design of a $400 million terminal at Atlanta's Hartsfield International Airport;

Whereas the Honorable Maynard Holbrook Jackson, Jr. helped to secure Atlanta's selection as the site of the 1996 Summer Olympics;

Whereas the Honorable Maynard Holbrook Jackson, Jr. served as president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became Chair of the National Voting Rights Institute of the Democratic National Committee;

Whereas the Honorable Maynard Holbrook Jackson, Jr. established the American Voters League, a nonpartisan organization committed to increasing voter turnout;

Whereas upon being elected Mayor of Atlanta, the Honorable Maynard Holbrook Jackson, Jr. began encouraging and fostering interracial understanding in Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a strong supporter of affirmative action, civil rights, and the expansion of social and economic gains for minorities;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a great champion for diversity, inclusion, and fairness–not just in government and business, but also in all areas of life;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a wonderful human being who never wavered from the principles that guided his life and career;

Whereas the efforts of the Honorable Maynard Holbrook Jackson, Jr. on behalf on the City of Atlanta and all Americans earned him the esteem and high regard of his colleagues; and

Whereas the untimely death of the Honorable Maynard Holbrook Jackson, Jr. has deprived his community, the City of Atlanta, the state of Georgia, and the entire Nation of an outstanding leader: Now, therefore, be it

Resolved: That the Senate—

(1) honors the life and accomplishments of the Honorable Maynard Holbrook Jackson Jr.;

(2) recognizes the legendary compassion exhibited by the Honorable Maynard Holbrook Jackson, Jr. as a civil rights leader; and

(3) extends its condolences to the Jackson family and the City of Atlanta on the death of a remarkable man.

The resolution (S. Res. 190) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 190

Whereas General Eric Shinseki, the Army's 34th Chief of Staff, retired in June 2003, from active military duty after 37 distinguished years of service;

Whereas General Shinseki, a native of Hawaii, graduated from the United States Military Academy, West Point, in 1965 and served in a variety of assignments, including 2 combat tours in Vietnam, and was wounded twice in combat while serving his country;

Whereas General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with oak leaf clusters), Bronze Star Medal with ''V'' Device (with 2 oak leaf clusters), Purple Heart (with oak leaf cluster), Meritorious Service Medal (with 2 oak leaf clusters), Air Medal, Army Commendation Medal (with oak leaf cluster), Army Achievement Medal, Parachutist Badge, Ranger Tab, Office of the Secretary of Defense Identification Badge, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge;

Whereas General Shinseki has spent the last 4 years of his career in the highest position attainable in the Army and has proven himself a tremendous leader who has demonstrated unselfish devotion to this Nation and the soldiers he leads;

Whereas General Shinseki focused the Army on improved readiness in preparation for war and transformed the Army into the lean, agile, lethal fighting force that achieved victories during Operations Enduring Freedom and Iraqi Freedom;

Whereas General Shinseki provided the vision to set the Army on a path of transformation that will provide the Nation with an Army that is more lethal, agile, deployable, and flexible; capable of fighting and winning this Nation's wars in all future threat environments.

Whereas General Shinseki exemplifies the trademark characteristics exhibited by all great leaders and is a remarkable man of integrity, courage, and honor;

Whereas General Shinseki is an American hero who has been selfless in his service to his country through war, peace, and personal trial, and epitomizes the spirit of aloha; and

Whereas John F. Kennedy, the 35th President of the United States once said, ''When at some future date the high court of history sits in judgment of each one of us—recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to 4 questions—were we truly men of courage . . . were we truly men of judgment . . . were we truly men of integrity . . . were we truly men of dedication?'' and whereas when history looks back at the Army's 34th Chief of Staff, it will be clear that this was truly a man of courage, judgment, integrity, and dedication: Now, therefore, be it

Resolved,

SECTION 1. COMMENDATION.

The Senate—

(1) thanks General Eric Shinseki of the United States Army on behalf of a grateful Nation; and

(2) commends General Eric Shinseki for his extraordinary dedication to service to this great country and for his lifetime of commitment to excellence.

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to General Eric Shinseki.

MEASURE READ THE FIRST TIME—S. 11

Mr. FRIST. Mr. President, I understand that S. 11 is at the desk, and I ask for its first reading.

The PRESIDING OFFICER. The clerk will read the bill by title for the first time.

The legislative clerk read as follows:

A bill (S. 11) to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

Mr. FRIST. I now ask for its second reading and object to further proceedings on this matter.

The PRESIDING OFFICER. Objection is heard. The bill will remain at the desk.

UNANIMOUS CONSENT AGREEMENT—ADJOURNMENT RESOLUTION

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate receives the adjournment resolution, it be agreed to and the motion to reconsider be laid upon the table, provided the text is identical to the resolution that is at the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR FRIDAY, JUNE 27, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 10:15 a.m., Friday, June 27. I further ask that following the prayer and the pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day and the Senate then begin a period for morning business with Members permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Tomorrow, the Senate will be in a period for morning business. Members will be able to pay tribute to our departed friend and colleague Strom Thurmond. We will give Members an opportunity to submit statements for the RECORD so they can be compiled for a printed tribute to Senator Thurmond. There will be no rollcall votes tomorrow.

Again, I thank my colleagues for their hard work over the past several weeks. We will have more to say about recent accomplishments of the Senate tomorrow and the events which culminated in tonight's passage—or this morning's passage—of the historic prescription drug benefits bill.

ADJOURNMENT UNTIL 10:15 A.M. TOMORROW

Mr. FRIST. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment as a mark of further respect for the late Senator Strom Thurmond.

There being no objection, the Senate, at 1:15 a.m., adjourned until Friday, June 27, 2003, at 10:15 a.m.

NOMINATIONS

Executive nominations received by the Senate June 26, 2003:

DEPARTMENT OF ENERGY

RICK A. DEARBORN, OF OKLAHOMA, TO BE AN ASSISTANT SECRETARY OF ENERGY (CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS), VICE DAN R. BROUILLETTE, RESIGNED.

OFFICE OF SPECIAL COUNSEL

SCOTT J. BLOCH, OF KANSAS, TO BE SPECIAL COUNSEL, OFFICE OF SPECIAL COUNSEL, FOR THE TERM OF FIVE YEARS, VICE ELAINE D. KAPLAN, RESIGNED.

DEPARTMENT OF HOMELAND SECURITY

PENROSE C. ALBRIGHT, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF HOMELAND SECURITY. (NEW POSITION)

DEPARTMENT OF JUSTICE

RENE ACOSTA, OF VIRGINIA, TO BE AN ASSISTANT ATTORNEY GENERAL, VICE RALPH F. BOYD, JR.

IN THE ARMY

THE FOLLOWING NAMED OFFICER TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

REGINA M. CURTIS, 0000

THE FOLLOWING NAMED OFFICER TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

NANCY M. PRICKETT, 0000

THE FOLLOWING NAMED OFFICERS TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

STEPHEN J. DEMSKI, 0000
JOSEPH F. MARANTO, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY IN THE JUDGE ADVOCATE GENERAL'S CORPS AND FOR REGULAR APPOINTMENT UNDER TITLE 10, U.S.C., SECTIONS 624, 531, AND 3064:

To be major

ANDREW S. KANTNER, 0000
DANIEL A. TANABE, 0000

CONFIRMATION

Executive nomination confirmed by the Senate June 26, 2003:

EXECUTIVE OFFICE OF THE PRESIDENT

JOSHUA B. BOLTEN, OF THE DISTRICT OF COLUMBIA, TO BE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET.

THE ABOVE NOMINATION WAS APPROVED SUBJECT TO THE NOMINEE'S COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

Daily Digest

HIGHLIGHTS

Senate passed S. 1—Prescription Drug and Medicare Improvement Act.

House Committee ordered reported the Defense and Legislative appropriations for fiscal year 2004.

House Committees ordered reported 11 sundry measures.

House passed H.R. 1, Medicare Prescription Drug, Modernization, Health Savings and Affordability Act.

House passed H.R. 2559, Military Construction Appropriations Act.

House passed H.R. 2417, Intelligence Authorization Act.

Senate

Chamber Action

Routine Proceedings, pages S8605–S8817

Measures Introduced: Thirty-one bills and six resolutions were introduced as follows: S. 11, S. 1338–1367, S. Res. 187–190, and S. Con. Res. 56–57. **Pages S8725–26**

Measures Reported:

S. 1025, to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, with amendments. (S. Rept. No. 108–80)

S. 1356, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004. (S. Rept. No. 108–81)

S. 1357, making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004. (S. Rept. No. 108–82)

S. 888, to reauthorize the Museum and Library Services Act. (S. Rept. No. 108–83)

S. Res. 62, calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

S. Res. 138, to amend rule XXII of the Standing Rules of the Senate relating to the consideration of nominations requiring the advice and consent of the Senate.

S. Res. 149, expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate, and with an amended preamble.

S. Res. 174, designating Thursday, November 20, 2003, as "Feed America Thursday".

S. Res. 175, designating the month of October 2003, as "Family History Month".

S. Res. 178, to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate wing of the Capitol and Senate office buildings for personal use.

S. 148, to provide for the Secretary of Homeland Security to be included in the line of Presidential succession. **Page S8722**

Measures Passed:

State Children's Health Insurance Program Amend Act: Senate passed S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program, after agreeing to the following amendment proposed thereto: **Pages S8633–35**

Grassley Amendment No. 1113, to make a technical correction. **Pages S8633–35**

Prescription Drug and Medicare Improvement Act: By yeas to nays (Vote No. 262), Senate passed S. 1, to amend title XVIII of the Social Security Act to make improvements in the Medicare program, to provide prescription drug coverage under the Medicare program, after agreeing to the committee amendment in the nature of a substitute, and after taking action on the following amendments proposed thereto: **Pages S8605–33, S8635–78, S8679–85, S8686–S8701**

Adopted:

Baucus (for Cantwell) Modified Amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a MedicareAdvantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements. **Pages S8606, S8612–17**

By 97 yeas to 1 nay (Vote No. 249), McConnell Amendment No. 1097, to protect seniors who are diagnosed with cancer from high prescription drug costs. **Pages S8621–22**

By 69 yeas to 29 nays (Vote No. 251), Bingaman/Domenici Modified Amendment No. 1065, to update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies. **Pages S8606, S8622–23**

Nelson (FL) Amendment No. 936, to provide for an extension of the demonstration for ESRD managed care. **Page S8606**

Nelson (FL) Amendment No. 938, to provide for a study and report on the propagation of concierge care. **Page S8606**

Thomas/Lincoln Modified Amendment No. 988, to provide for the coverage of marriage and family therapist services and mental health counselor services under part B of the Medicare program. **Page S8606**

Baucus (for Snowe) Amendment No. 1027, to express the sense of the Senate regarding the implementation of the Prescription Drug and Medicare Improvement Act of 2003. **Page S8633**

Baucus (for Murkowski/Stevens) Amendment No. 1041, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project. **Pages S8633, S8687**

Subsequently, the adoption of Amendment No. 1041 (listed above) was vitiated. **Page S8633**

By a unanimous vote of 98 yeas (Vote No. 252), McConnell Amendment No. 1102, to protect seniors who are diagnosed with Alzheimer's disease from high prescription drug costs. **Pages S8624, S8635–36**

Subsequently, the amendment was modified. **Page S8635**

By 71 yeas to 26 nays (Vote No. 255), Grassley/Baucus Modified Amendment No. 1092, to evaluate alternative payment and delivery systems. **Pages S8606, S8610–12, S8618–21, S8637–38**

Grassley (for Bond) Amendment No. 1014, to include pharmacy services in the study relating to outpatient pharmacy therapy reimbursements. **Page S8614**

Baucus (for Dodd) Amendment No. 1015, to provide for a study on making prescription pharmaceutical information accessible for blind and visually-impaired individuals. **Page S8647**

Grassley (for Hatch) Amendment No. 1059, to direct the Secretary of Health and Human Services to conduct a review and report on current standards of practice for pharmacy services provided to patients in nursing facilities. **Page S8647**

Grassley (for Hatch/Wyden) Amendment No. 1106, to establish a Citizens Health Care Working Group to facilitate public debate about how to improve the health care system for Americans and to provide for hearings by Congress on the recommendations that are derived from this debate. **Page S8647**

Grassley (for Murkowski) Amendment No. 1086, to ensure that pharmacies operated by the Indian Health Service and Indian health programs are included in the network of pharmacies established by entities and organizations under part D. **Page S8647**

Baucus (for Mikulski) Modified Amendment No. 1033, to extend certain municipal health service demonstration projects. **Page S8644**

Baucus (for Lincoln) Modified Amendment No. 1067, to provide coverage for kidney disease education services under the Medicare program. **Pages S8644–47**

Lincoln Amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare program. **Page S8606**

Lincoln Amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs. **Page S8606**

Reid (for Jeffords) Amendment No. 1038, to improve the critical access hospital program. **Page S8606**

Reid (for Johnson/Cochran) Amendment No. 1095, to provide for a 1-year medication therapy management assessment program. **Pages S8617–18**

Grassley (for Murkowski/Stevens) Amendment No. 1096, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project. **Page S8681**

Grassley (for Brownback/Nelson (NE)) Amendment No. 1122, to provide for improvements in access to services in rural hospitals and critical access hospitals. **Page S8681**

Grassley (for Coleman) Amendment No. 1074, to amend title XVIII of the Social Security Act to make improvements in the national coverage determination process to respond to changes in technology. **Page S8681**

Grassley (for Collins) Amendment No. 1023, to provide for the establishment of a demonstration project to clarify the definition of homebound. **Pages S8681–82**

Grassley (for Kyl) Amendment No. 1114, to require the GAO to study the impact of price controls on pharmaceuticals. **Page S8682**

Grassley (for Kyl) Amendment No. 1115, to express the sense of the Senate concerning Medicare payments to physicians and other health professionals. **Page S8681**

Grassley (for Chambliss) Amendment No. 1045, to provide for a demonstration project for the exclusion of brachytherapy devices from the prospective payment system for outpatient hospital services. **Pages S8682–83**

Grassley (for Craig) Amendment No. 1058, to restore the Federal Hospital Insurance Trust Fund to the financial position it would have been in if a clerical bookkeeping error had not occurred. **Page S8681**

Grassley (for Baucus) Amendment No. 1117, to establish the Safety Net Organizations and Patient Advisory Commission. **Page S8681**

Grassley (for Bayh) Amendment No. 1044, to adjust the urban health provider payment. **Page S8683**

Grassley (for Shelby) Amendment No. 1056, to prevent the Secretary of Health and Human Services from modifying the treatment of certain long-term care hospitals as subsection (d) hospitals. **Page S8681**

Grassley (for Murray) Modified Amendment No. 961, to make improvements in the Medicare-Advantage benchmark determinations. **Page S8681**

Grassley (for Bond/Roberts) Amendment No. 1013, to ensure that patients are receiving safe and accurate dosages of compounded drugs. **Page S8681**

Grassley (for Kyl) Amendment No. 1121, to express the sense of the Senate concerning the structure of Medicare reform and the prescription drug benefit to ensure Medicare's long-term solvency and high quality of care. **Pages S8683–84**

Grassley (for Collins) Modified No. 989, to increase Medicare payments for home health services furnished in a rural area. **Pages S8681, S8684**

Grassley (for Dole/Edwards) Amendment No. 1126, to provide for the treatment of certain entities for purposes of payments under the Medicare program. **Page S8681**

Grassley (for Reed) Amendment No. 996, to modify the GAO study of geographic differences in payments for physicians' services relating to the work geographic practice cost index. **Page S8684**

Grassley (for Specter) Amendment No. 1118, to express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries. **Pages S8653–54, S8684**

Grassley (for Specter) Amendment No. 1085, to express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule. **Pages S8652–53, S8685**

Allard/Feingold Amendment No. 1017, to provide for temporary suspension of OASIS requirement for collection of data on non-Medicare and non-Medicaid patients. **Pages S8608–09**

Baucus (for Harkin) Amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents. **Page S8606**

Graham (SC) Modified Amendment No. 948, to provide for the establishment of a National Bipartisan Commission on Medicare Reform. **Page S8606**

Dayton Modified Amendment No. 960, to require a streamlining of the Medicare regulations. **Pages S8606, S8680, S8685**

Baucus (for Feingold) Amendment No. 1054, to establish an Office of the Medicare Beneficiary Advocate. **Page S8612**

Enzi Amendment No. 1030, to encourage the availability of MedicareAdvantagebenefits in medically underserved areas. **Page S8606**

Grassley Amendment No. 1133, to provide for a managers' amendment. **Pages S8686–87**

Rejected:

Harkin Modified Amendment No. 991, to establish a demonstration project under the Medicaid program to encourage the provision of community-based services to individuals with disabilities. (By 50 yeas to 48 nays (Vote No. 247), Senate tabled the amendment.) **Pages S8606–09**

By 39 yeas to 59 nays (Vote No. 248), Edwards/Harkin Amendment No. 1052, to strengthen protections for consumers against misleading direct-to-consumer drug advertising. **Pages S8606, S8609–10**

Reid (for Boxer) Amendment No. 1036, to eliminate the coverage gap forindividuals with cancer. (By 55 yeas to 44 nays (Vote No. 250), Senate tabled the amendment.) **Pages S8606, S8622**

Durbin Amendment No. 1108, to provide additional assistance for certain eligible beneficiaries under part D. (By 57 yeas to 41 nays (Vote No. 253), Senate tabled the amendment.) **Pages S8630–32, S8636–37**

By 39 yeas to 59 nays (Vote No. 254), Dorgan/Pryor Amendment No. 1103 (toAmendment No. 1092), to reduce aggregate beneficiary obligations by $2,400,000,000 per year beginning in 2009. **Pages S8625–30, S8637**

By 33 yeas to 65 nays (Vote No. 256), Sessions Amendment No. 1011, to express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under Medicaid and SCHIP as part of thereauthorization of the temporary assistance for needy families program.

Pages S8606, S8642, S8644, S8647

By 47 yeas to 51 nays (Vote No. 257), Rockefeller Modified Amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage. **Pages S8606, S8639–41, S8644, S8647–48**

By 43 yeas to 55 nays (Vote No. 258), Bingaman Amendment No. 1066, to permit the establishment of 2 new Medigap plans for Medicare beneficiaries enrolled for prescription drug coverage under part D.

Pages S8606, S8641–42, S8648

By 42 yeas to 54 nays (Vote No. 259), Baucus (for Levin) Amendment No. 1111, to ensure that current retirees who have prescription drug coverage who will lose their prescription drug coverage as a result of the enactment of this legislation have the option of drug coverage under the Medicare fallback.

Pages S8632, S8660–63, S8674

By 21 yeas to 75 nays (Vote No. 260), Hagel/Ensign Modified Amendment No. 1026, to provide Medicare beneficiaries with a drug discount card that ensures access to affordable prescription drugs.

Pages S8606 S8663–75

Baucus (for Feinstein) Modified Amendment No. 1060, to provide for an income-relatedincrease in the part B premium for individuals with income in excess of $75,000 and marriedcouples with income in excess of $150,000. (By 38 yeas to 59 nays (Vote No. 261), Senateearlier failed to table the amendment.) **Pages S8606, S8675–78, S8680**

Withdrawn:

Kyl Amendment No. 1093 (to Amendment No. 1092), in the nature of a substitute.

Pages S8606, S8624

Grassley (for Craig) Amendment No. 1087, topermit the offering of consumer-driven health plans under MedicareAdvantage.

Pages S8606, S8651–52

Santorum Amendment No. 1132, to allow eligible beneficiaries in MedicareAdvantageplans to elect zero premium, stop-loss drug coverage protection.

Pages S8679–80

Kerry Amendment No. 958, to increase the availability of discounted prescription drugs.

Pages S8606, S8687

Lincoln Modified Amendment No. 934, to ensure coverage for syringes for theadministration of insulin, and necessary medical supplies associated with the administration ofinsulin. **Pages S8606 S8687**

Baucus (for Jeffords) Amendment No. 964, to include coverage for tobacco cessationproducts.

Pages S8606, S8687

Baucus (for Jeffords) Amendment No. 965, to establish a Council for Technology and Innovation.

Pages S8606, S8687

Akaka Amendment No. 980, toexpand assistance with coverage for legalimmigrants under the Medicaid program and SCHIP to include citizens of the Freely AssociatedStates. **Pages S8606, S8687**

Akaka Amendment No. 979, to ensure that current prescription drug benefits toMedicare-eligible enrollees in the Federal Employees Health Benefits Program will not bediminished. **Pages S8606, S8687**

Bingaman Amendment No. 973, to amend title XVIII of the Social Security Act toprovide for the authorization of reimbursement for all Medicare part B services furnished bycertain Indian hospitals and clinics. **Pages S8606, S8687**

Baucus (for Lautenberg) Amendment No. 986, to make prescription drug coverageavailable beginning on July 1, 2004. **Page S8606**

Murray Amendment No. 990, to make improvements in the MedicareAdvantagebenchmark determinations. **Pages S8606, S8680, S8687**

Dayton Amendment No. 977, to require that benefits be made available under part D on January 1, 2004. **Page S8687**

Baucus (for Dorgan) Amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare program. **Pages S8606, S8687**

Smith/Bingaman Amendment No. 962, to provide reimbursement for Federally qualified health centers participating in Medicare managed care.

Pages S8606, S8687

Hutchison Amendment No. 1004, to amend title XVIII of the Social Security Act tofreeze the indirect medical education adjustment percentage under the Medicare program at 6.5percent. **Pages S8606, S8687**

Conrad Amendment No. 1019, toprovide for coverage of self-injected biologicalsunder part B of the Medicare program until Medicare Prescription Drug plans are available. **Pages S8606, S8687**

Conrad Amendment No. 1020, to permanently and fully equalize the standardizedpayment rate beginning in fiscal year 2004. **Pages S8606, S8687**

Conrad Amendment No. 1021, toaddress Medicare payment inequities. **Pages S8606, S8687**

Clinton Amendment No. 999, to provide for the development of quality indicators for thepriority areas of the Institute of Medicine, for the standardization of quality indicators for Federalagencies, and for the establishment of a demonstration program for the reporting of health carequality data at the community level. **Pages S8606, S8687**

Clinton Amendment No. 953, toprovide training to long-term care ombudsman. **Pages S8606, S8687**

Clinton Amendment No. 954, to require the Secretary of Health and Human Services todevelop literacy standards for informational materials, particularly drug information. **Pages S8606, S8687**

Reid (for Corzine) Modified Amendment No. 1037, toprovide conforming changesregarding federally qualified health centers. **Pages S8606, S8632**

Reid (for Inouye) Amendment No. 1039, to amend title XIX of the Social Security Act toprovide 100 percent reimbursement for medical assistance provided to a Native Hawaiianthrough a Federally-qualified health center or a Native Hawaiian health care system. **Page S8606**

Enzi/Lincoln Amendment No. 1051, toensure convenient access to pharmacies and prohibit the tying of contracts. **Pages S8606, S8687**

Hagel/Ensign Amendment No. 1012, to provide Medicare beneficiaries with an additionalchoice of Medicare Prescription Drug plans under part D that consists of a drug discount cardand protection against high out-of-pocket drug costs. **Pages S8606, S8687**

Baucus (for Akaka) Amendment No. 1061, to provide for treatment of Hawaii as a low-DSH State for purposes of determining a Medicaid DSH allotment for the State for fiscal years2004 and 2005. **Pages S8606, S8687**

Stabenow/Levin Amendment No. 1075, to permanently extend a moratorium on thetreatment of a certain facility as an institution for mental diseases. **Pages S8606, S8687**

Stabenow/Levin Amendment No. 1076, toprovide for the treatment of payments tocertain comprehensive cancer centers. **Pages S8606, S8687**

Stabenow/Levin Amendment No. 1077, to provide for the redistribution of unusedresident positions. **Pages S8606, S8687**

Ensign/Lincoln Amendment No. 1024, to amend title XVIII of the Social Security Act torepeal the Medicare outpatient rehabilitation therapy caps. **Pages S8606, S8687**

Smith/Feingold Amendment No. 1073, to allow the Secretary to include in the definitionof 'specialized Medicare+Choice plans for special needs beneficiaries' plans that disproportionately serve such special needs beneficiaries or frail, elderly Medicare beneficiaries. **Pages S8606, S8687**

Baucus (for Mikulski) Amendment No. 1088, to provide equitable treatment for children's hospitals. **Pages S8606, S8687**

Baucus (for Mikulski) Amendment No. 1089, to provide equitable treatment for certain children's hospitals. **Pages S8606, S8687**

Baucus (for Mikulski) Amendment No. 1090, to permit direct payment under the Medicare program for clinical social worker services provided to residents of skilled nursing facilities. **Pages S8606, S8687**

Baucus (for Mikulski) Amendment No. 1091, to extend certain municipal health service demonstration projects. **Pages S8606, S8687**

Baucus (for Levin) Amendment No. 1110, to ensure that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan. **Pages S8632, S8687**

Baucus (for Murkowski/Stevens) Amendment No. 1041, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project. **Page S8687**

A unanimous-consent agreement was reached providing that following passage of S. 1 (listed above), the bill be held at the desk, and when the Senate receives H.R. 1, House companion measure, all after the enacting clause be stricken and the text of S. 1 be inserted in lieu thereof; Senate insisted on its amendment, request a conference with the House thereon, and the Chair be authorized to appoint conference on the part of the Senate; providing further, passage of S. 1 be vitiated and the bill be returned to the Senate Calendar. **Page S8811**

Check Truncation Act: Senate passed H.R. 1474, to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, after striking all after the enacting clause and inserting the text of S. 1334, Senate companion measure. **Pages S8811–15**

Subsequently, S. 1334 was returned to the Senate Calendar. **Page S8811**

Commending August Hiebert: Senate agreed to S. Res. 186, commending August Hiebert for his service to the Alaska Communications Industry. **Pages S8815–16**

Rhodes Scholarships: Senate agreed to S. Res. 187, expressing the sense of the Senate regarding the centenary of the Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation. **Pages S8815–16**

Honoring Maynard Holbrook Jackson, Jr.: Senate agreed to S. Res. 188, honoring Maynard Holbook Jackson, Jr., former Mayor of the City of Atlanta, and extending the condolences of the Senate on his death. **Pages S8815–16**

Commending General Eric Shinseki: Senate agreed to S. Res. 190, commending General Eric

Shinseki of the United States Army for his outstanding service and commitment to excellence.

Pages S8815–16

Adjournment Resolution—Agreement: A unanimous-consent agreement was reached providing that when the Senate receives an adjournment resolution from the House, it be agreed to, providing that the text is identical to the resolution being held at the desk. Page S8816

Nominations Confirmed: Senate confirmed the following nominations:

Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget. Page S8817

Nominations Received: Senate received the following nominations:

Rick A. Dearborn, of Oklahoma, to be an Assistant Secretary of Energy (Congressional and Intergovernmental Affairs).

Scott J. Bloch, of Kansas, to be Special Counsel, Office of Special Counsel, for the term of five years.

Penrose C. Albright, of Virginia, to be an Assistant Secretary of Homeland Security. (New Position)

Rene Acosta, of Virginia, to be an Assistant Attorney General

Routine lists in the Army. Page S8817

Messages From the House: Pages S8719–20

Measures Referred: Page S8720

Measures Placed on Calendar: Page S8720

Measures Read First Time: Page S8720

Executive Communications: Pages S8720–22

Executive Reports of Committees: Pages S8722–25

Additional Cosponsors: Pages S8726–29

Statements on Introduced Bills/Resolutions: Pages S8729–65

Additional Statements: Pages S8716–19

Amendments Submitted: Pages S8765–S8810

Authority for Committees To Meet: Pages S8810–11

Record Votes: Sixteen record votes were taken today. (Total—262)

Pages S8609–10 S8622–23, S8636–38, S8647–48, S8674–75, S8686, S8707

Adjournment: Senate met at 9:15 a.m., and adjourned at 1:15 a.m. on Friday, June 27, 2003, until 10:15 a.m., on the same day. (For Senate's program, see the remarks of the Majority Leader in today's Record on page S8817.)

Committee Meetings

(Committees not listed did not meet)

HEALTHY FORESTS RESTORATION ACT

Committee on Agriculture, Nutrition, and Forestry: Committee concluded hearings to examine H.R. 1904, to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, after receiving testimony from Senator McCain; Mark Rey, Under Secretary of Agriculture for Natural Resources and the Environment; Lynn Scarlett, Assistant Secretary of the Interior for Policy, Management, and Budget; Michael Carroll, Minnesota State Forester, St. Paul, on behalf of the National Association of State Foresters; Frederick M. Stephen, University of Arkansas, Fayetteville, on behalf of the Society of American Foresters; Tom Nelson, Sierra Pacific Industries, Redding, California, on behalf of the American Forest and Paper Association; Jacquellin L. McAvoy, City Council, Post Falls, Idaho, on behalf of the Idaho Women in Timber; Michael Petersen, The Lands Council, Spokane, Washington; Norman L. Christensen, Jr., Duke University Nicholas School of the Environment and Earth Sciences, Durham, North Carolina; Hal Salwasser, Oregon State University Department of Forest Resources, Corvallis; Donald J. Kochan, George Mason University School of Law, Arlington, Virginia; and Patrick Parenteau, Vermont Law School, South Royalton.

APPROPRIATIONS—LABOR/HHS/ EDUCATION AND MILITARY CONSTRUCTION

Committee on Appropriations: Committee ordered favorably reported the following business bills:

An original bill (S. 1356) making appropriations for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 2004; and

An original bill (S. 1357) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004.

FAIR CREDIT REPORTING ACT

Committee on Banking, Housing, and Urban Affairs: Committee concluded hearings to examine affiliate

sharing practices in relation to the Fair Credit Reporting Act, focusing on privacy protections, security risks and threats to the credit reporting system, retail credit card programs, and merchandise returns, after receiving testimony from Vermont Assistant Attorney General Julie Brill, Montpelier; Joel R. Reidenberg, Fordham University School of Law, and Martin Wong, Citigroup, Inc., both of New York, New York; Ronald A. Prill, Target Financial Services, Minneapolis, Minnesota, on behalf of the National Retail Federation; Edmund Mierzwinski, U.S. Public Interest Research Group, Washington, D.C.; Terry Baloun, Wells Fargo Bank, Sioux Falls, South Dakota; and Angela Maynard, Keycorp, Cleveland, Ohio.

BUSINESS MEETING

Committee on Commerce, Science, and Transportation: Committee ordered favorably reported the following business items:

S. 1264, to reauthorize the Federal Communications Commission, with amendments;

H.R. 1320, to amend the National Telecommunications and Information Administration Organization Act to facilitate the reallocation of spectrum from governmental to commercial users, with an amendment;

An original bill to authorize funds for highway safety programs, motor carrier safety programs, hazardous materials transportation safety programs, and boating safety programs;

S. 1262, to authorize appropriations for fiscal years 2004, 2005, and 2006 for certain maritime programs of the Department of Transportation, with amendments; and

S. 1218, to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program, with an amendment in the nature of a substitute.

NOMINATIONS:

Committee on Finance: Committee concluded hearings to examine the nominations of Josette Sheeran Shiner, of Virginia, to be a Deputy United States Trade Representative, with the rank of Ambassador, and James J. Jochum, of Virginia, to be an Assistant Secretary of Commerce, after each nominee testified and answered questions in their own behalf.

BUSINESS MEETING

Committee on Foreign Relations: Committee ordered favorably reported the following business items:

S. Res. 90, expressing the sense of the Senate that the Senate strongly supports the nonproliferation programs of the United States, with an amendment;

S. Res. 62, calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba;

S. Res. 149, expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate, with an amendment; and

The nominations of Robert W. Fitts, of New Hampshire, to be Ambassador to Papua New Guinea, and to serve concurrently and without additional compensation as Ambassador to the Solomon Islands and Ambassador to the Republic of Vanuatu, Marsha E. Barnes, of Maryland, to be Ambassador to the Republic of Suriname, John E. Herbst, of Virginia, to be Ambassador toUkraine, Tracey Ann Jacobson, of the District of Columbia, to be Ambassador to Turkmenistan, George A. Krol, of New Jersey, to be Ambassador to the Republic of Belarus, John F. Maisto, of Pennsylvania, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador, Greta N. Morris, of California, to be Ambassador to the Republic of the Marshall Islands, Roger Francisco Noriega, of Kansas, to be an Assistant Secretary of State (Western Hemisphere Affairs), William B. Wood, of New York, to be Ambassador to the Republic of Colombia, and certain Foreign Service Officer promotion lists.

INTERNATIONAL PARENTAL ABDUCTION

Committee on Foreign Relations: Committee concluded hearings to examine the Department of State's Office of Children's Issues, focusing on responding to international parental abduction, after receiving testimony from Senator Lincoln; and Maura Harty, Assistant Secretary of State, Bureau of Consular Affairs.

NOMINATIONS:

Committee on Governmental Affairs: Committee ordered favorably reported the nominations of Judith Nan Macaluso, to be an Associate Judge of the Superior Court of the District of Columbia; Fern Flanagan Saddler, to be an Associate Judge of the Superior Court of the District of Columbia; and Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.

BUSINESS MEETING

Committee on Indian Affairs: Committee ordered favorably reported the following business items:

S. 281, to amend the Transportation Equity Act for the 21st Century to make certain amendments with respect to Indian tribes, to provide for training

and technical assistance to Native Americans who are interested in commercial vehicle driving careers, with an amendment in the nature of a substitute; and

The nominations of Lisa Genevieve Nason, of Alaska, Georgianna E. Ignace, of Wisconsin, John Richard Grimes, of Massachusetts, each to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development, and Charles W. Grim, of Oklahoma, to be Director of the Indian Health Service, Department of Health and Human Services.

BUSINESS MEETING

Committee on the Judiciary: Committee ordered favorably reported the following business items:

S. Res. 174, designating Thursday, November 20, 2003, as "Feed America Thursday";

S. Res. 175, designating the month of October 2003, as "Family History Month"; and

The nominations of Diane M. Stuart, of Utah, to be Director of the Violence Against Women Office, Department of Justice; and Thomas M. Hardiman, to be United States District Judge for the Western District of Pennsylvania.

Also, committee resumed markup of S. 1125, to create a fair and efficient system to resolve claims of victims for bodily injury caused by asbestos exposure, but did not complete action thereon, and recessed subject to call.

GROWING WAHHABI INFLUENCE

Committee on the Judiciary: Subcommittee on Terrorism, Technology, and Homeland Security concluded hearings to examine the ideological structure of Wahhabism, an extreme and violent form of Islam, and its potential for politcal and social influence in the United States, after receiving testimony from David Aufhauser, General Counsel, Department of the Treasury; Larry A. Mefford, Assistant Director, Counterterrorism Division, Federal Bureau of Investigation, Department of Justice; and Alex Alexiev, Center for Security Policy, and Stephen Schwartz, Foundation for Defense of Democracies, both of Washington, D.C.

House of Representatives

Chamber Action

Measures Introduced: 68 public bills, H.R. 2607–2656; and; 18 resolutions, H.J. Res. 62; H. Con. Res., 231–239 and H. Res. 300–307, were introduced. **Pages H6261–64**

Additional Cosponsors: **Pages H6264–65**

Reports Filed: Reports were filed today as follows:

H.R. 438, to increase the amount of student loans that may be forgiven for teachers in mathematics, science, and special education, amended (H. Rept. 108–182);

H.R. 2211, to reauthorize title II of the Higher Education Act of 1965, amended (H. Rept. 108–183);

H.R. 2210, to reauthorize the Head Start Act to improve the school readiness of disadvantaged children, amended (H. Rept. 108–184); and

H.R. 74, to direct the Secretary of Agriculture to convey certain land in the lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California (H. Rept. 108–185). **Page H6261**

Guest Chaplain: The prayer was offered by the guest Chaplain, Rabbi Milton Balkany, Dean, Bais Yaakov of Brooklyn, New York. **Page H5941**

Journal: Agreed to the Speaker's approval of the Journal of June 25 by yea-and-nay vote of 357 yeas to 68 nays, Roll No. 327. **Page H5941**

Intelligence Authorization Act for FY 2004: The House passed H.R. 2417, to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System by yea-and-nay vote of 410 yeas to 9 nays, Roll No. 333. The House completed general debate and began considering amendments to the bill on June 25. **Pages H5943–46, H6256–57**

Agreed To:

Hastings of Florida amendment No. 4 printed in H. Rept. 108–176, debated on June 25, that directs the Director of Central Intelligence to establish a pilot project to improve recruitment of ethnic and cultural minorities and women with diverse skills and language abilities (agreed to by recorded vote of 418 ayes with none voting "no", Roll No. 318; **Pages H5943–44**

Rejected:

Kucinich amendment No. 5 printed in H. Rept. 108–176, debated on June 25, that sought to direct the Inspector General of the Central Intelligence

Agency to conduct an audit of all communications between the CIA and the Office of the Vice President that relate to weapons of mass destruction obtained or developed by Iraq (rejected by recorded vote of 76 ayes to 347 noes, Roll No. 319); and

Pages H5944–45

Lee amendment No. 6 printed in H. Rept. 108–176, debated on June 25, that sought to require a GAO study on intelligence sharing by the Department of Defense and intelligence community with United Nations inspectors searching for weapons of mass destruction (rejected by recorded vote of 185 ayes to 239, Roll No. 320. **Pages H5945–46**

H. Res. 295, the rule that provided for consideration of the bill was agreed to on June 25.

Page H5946

Recess: The House recessed at 11:48 a.m. and reconvened at 12:53 p.m. **Pages H5951–52**

Motions to Suspend the Rules on Wednesdays During the Remainder of the One Hundred Eighth Congress: The House agreed to H. Res. 297, providing for motions to suspend the rules by recorded vote of 226 ayes to 203 noes, Roll No. 323. **Pages H5946–51, H5973–74**

Late Report: The Committee on Appropriations received permission to have until midnight to file a privileged report making appropriations for the Legislative Branch for the fiscal year ending September 30, 2004. **Page H5979**

Military Construction Appropriations Act: The House passed H.R. 2559, making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004 by yea-and-nay vote of 428 yeas with none voting "nay", Roll No. 325. **Pages H5974–90**

Rejected the Obey motion to recommit the bill to the Committee on Appropriations. Earlier, a point of order was sustained against another Obey motion that sought to recommit the bill to the Committee on Appropriations with instructions to report it back forthwith with an amendment that increases funding for various programs including fitness facilities, family housing, and barracks. **Page H5986**

Point of order was sustained against the Obey amendment that sought to reinstate funding for various programs including fitness facilities, family housing, and barracks. **Pages H5989–90**

Earlier, the House agreed to H. Res. 298, the rule that provided for consideration of the bill by voice vote. Agreed to order the previous question by yea-and-nay vote of 220 yeas to 200 nays, Roll No. 324. **Pages H5978–79**

Suspension—Support for Freedom in Hong Kong: The House agreed to suspend the rules and agree to H. Res. 277, expressing support for freedom in Hong Kong (agreed to by 2/3 yea-and-nay vote of 426 yeas to 1 nay, Roll No. 326). The motion was debated on June 25. **Pages H5990–91**

Order of Business—DoD Appropriations: Agreed that it be in order on Tuesday, July 8, for the Speaker, as though pursuant to clause 2(b) of rule 18, to declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of a bill reported pursuant to section 6 of H. Res. 299, making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, which shall proceed according to the following order: the first reading shall be dispensed with; all points of order against consideration of the bill are waived; general debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations; after general debate the bill shall be considered for amendment under the five-minute rule; points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived; during consideration of the bill for amendment, the Chairman of theCommittee of the Whole may accord priority in recognition on the basis of whether the member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. **Page H5992**

State Children's Health Insurance Program (SCHIP) Allotments: The House passed H.R. 531, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP) by unanimous consent. **Pages H6006–07**

Medicare Prescription Drug, Modernization, Health Savings and Affordability Act: The House passed H.R. 1, to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program and to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed

to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements by 216 ayes to 215 noes with 1 voting "present," Roll No. 332.

Pages H6007–H6105, H6107–H6256

Pursuant to Section 3 of the rule in the engrossment of H.R. 1, the Clerk shall add the text of H.R. 2596, as passed by the House as a new matter at the end of H.R. 1, conform the title of H.R. 1 to reflect the addition of the text of H.R. 2596 to the engrossment, and then lay H.R. 2596 on the table.

Page H6256

Rejected the Thompson of California motion to recommit the bill jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with amendments in the nature of a substitute that establish the Prescription Drug and Medicare Improvement Act. By recorded vote of 208 ayes to 223 noes, Roll No. 331.

Pages H6181–H6255

Rejected the Rangel amendment in the nature of a substitute numbered 1 printed in H. Rept. 108–181 that sought to provide prescription drug coverage for all Medicare beneficiaries, enhance Medicare+Choice plans, includes payments for oncology providers and related cancer drug therapy programs; improve rural health delivery; and implement various provisions dealing with Medicare Parts A and B, Medicaid, regulatory reduction and the reimportation of prescription drugs by recorded vote of 176 ayes to 255 noes with 1 voting "present", Roll No. 330. **Page H6181**

H. Res. 299, the rule that providing for consideration of both H.R. 1, Medicare Prescription Drug and Modernization Act, and H.R. 2596, Health Savings and Affordability Act was agreed to by recorded vote of 221 ayes to 203 noes, Roll No. 322. Earlier agreed to order the previous question by yea-and-nay vote of 226 yeas to 203 nays, Roll No. 321.

Pages H5972–73

Health Savings and Affordability Act: The House passed H.R. 2596, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements by yea-and-nay vote of 237 yeas to 191 nays, Roll No. 328.

Pages H5952–73, H5992–H6006

Section 3 of H. Res. 299, the rule providing for consideration of the bill, provides that in the engrossment of H.R. 1, the clerk shall add the text of H.R. 2596, as passed by the House as a new matter at the end of H.R. 1, and then lay H.R. 2596 on the table. **Page H6256**

Independence Day District Work Period: The House agreed to H. Con. Res. 231, providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate. **Page H6257**

Senate Concurrence in Adjournment Resolution: Agreed that when the House adjourns today, it adjourn to meet at 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its concurrence in H. Con. Res. 231, in which case the House shall stand adjourned pursuant to that concurrent resolution. **Page H6257**

Calendar Wednesday: Agreed to dispense with the Calendar Wednesday business of Wednesday, July 9. **Page H6257**

Speaker Pro Tempore: Read a letter from the Speaker wherein he appointed Representative Tom Davis of Virginia to act as Speaker pro tempore to sign enrolled bills and joint resolutions through Monday, July 7. **Page H6257**

Senate Messages: Messages received from the Senate today appear on pages H5941, and H5992.

Referrals: S. 163 was referred to the Committees on Education and the Workforce and Resources, S. 498 was referred to the Committee on Financial Services, S. 867 was referred to the Committee on Government Reform, and S. 1207 and S. 312 were held at the desk. **Page H6258**

Call of the House: On the Call of the House, 421 members reported their presence, Roll No. 329. **Page H6178**

Quorum Calls—Votes: One quorum call, Roll No. 329, eight yea-and-nay votes and seven recorded votes developed during the proceedings of the House today and appear on pages H5944, H5944–45, H5945–46, H5972–73, H5973, H5973–74, H5978–79, H5990, H5990–91, H5991–92, H6006, H6178, H6181, H6255, H6255–56, and H6256–57. There were no quorum calls.

Adjournment: The House met at 10 a.m. and at 2:47 a.m. on Friday, June 27, pursuant to the provisions of H. Con. Res. 231, the House stands adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of H. Con. Res. 231, in which case the House shall stand adjourned pursuant to that concurrent resolution until 2 p.m. on Monday, July 7.

Committee Meetings

MANDATORY COUNTRY OF ORIGIN LABELING LAW REVIEW

Committee on Agriculture: Held a hearing to review the mandatory country of origin labeling law. Testimony was heard from the following officials of the USDA: Charles Lambert, Deputy Under Secretary, Marketing and Regulatory Programs; Nancy Bryson, General Counsel; and Keith Collins, Chief Economist; and public witnesses.

DEFENSE AND LEGISLATIVE APPROPRIATIONS

Committee on Appropriations: Ordered reported the following appropriations for fiscal year 2004: Defense and Legislative.

FOREIGN RELATIONS AUTHORIZATION ACT

Committee on Armed Services: Ordered reported, as amended, H.R. 1950, Foreign Relations Authorization Act, Fiscal Years 2004 and 2005.

FINANCIAL MAINSTREAM—BROADEN ACCESS

Committee on Financial Services: Subcommittee on Financial Institutions and Consumer Credit held a hearing entitled "Serving the Underserved: Initiatives to Broaden Access to the Financial Mainstream." Testimony was heard from Wayne Abernathy, Assistant Secretary, Financial Institutions, Department of the Treasury; Dennis Dollar, Chairman, National Credit Union Administration; and public witnesses.

COMPETITIVE SOURCING FOR 21ST CENTURY

Committee on Government Reform: Held a hearing titled "New Century, New Process: A Preview of Competitive Sourcing for the 21st Century." Testimony was heard from David M. Walker, Comptroller, GAO; Angela Styles, Director, Office of Federal Procurement Policy, OMB; Philip Grone, Principal Assistant Deputy Under Secretary, Installations and Environment, Department of Defense; Scott J. Cameron, Deputy Assistant Secretary, Performance and Management, Department of the Interior; and public witnesses.

ASIA AND THE PACIFIC—U.S. SECURITY POLICY

Committee on International Relations: Subcommittee on East Asia and the Pacific held a hearing on U.S. Security Policy in Asia and the Pacific: Restructuring America's Forward Deployment. Testimony was heard from the following officials of the Department of Defense: Peter Rodman, Assistant Secretary, International Security Affairs; and Adm. Thomas B. Fargo, USN, Commander, U.S. Pacific Command; and Christopher LaFleur, Special Envoy, Northeast Asia Security Consultations, Bureau of East Asian and Pacific Affairs, Department of State.

AMERICAN SERVICEMEMBERS' PROTECTION ACT AMENDMENTS

Committee on International Relations: Subcommittee on Europe approved for full Committee action H.R. 2550, to amend the American Servicemembers' Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States miliary assistance.

HOMETOWN HEROES SURVIVORS BENEFITS

Committee on the Judiciary: Subcommittee on Crime, Terrorism, and Homeland Security held a hearing on H.R. 919, Hometown Heroes Survivors Benefits. Testimony was heard from Michael E. Williams, Jr., Fire Rescue Training Specialist, Office of the State Fire Marshall, Department of Insurance, State of North Carolina; and public witnesses.

OVERSIGHT—CONSULAR IDENTIFICATION CARDS

Committee on the Judiciary: Subcommittee on Immigration, Border Security, and Claims held an oversight hearing on "The Federal Government's Response to the Issuance and Acceptance in the U.S. of Consular Identification Cards." Testimony was heard from Roberta S. Jacobson, Acting Deputy Assistant Secretary, Bureau of Western Hemisphere Affairs, Department of State; Steven McCraw, Assistant Director, Office of Intelligence, FBI, Department of Justice; C. Stewart Verdery, Assistant Secretary, Policy and Planning, Border and Transportation Security Directorate, Department of Homeland Security; and a public witness.

MISCELLANEOUS MEASURES

Committee on Resources: Subcommittee on Fisheries Conservation, Wildlife and Oceans held a hearing on the following bills: H.R. 1204, to amend the National Wildlife Refuge System Administration Act of 1966 to establish requirements for the award of concessions in the National Wildlife Refuge System, to provide for maintenance and repair of properties located in the System by concessionaires authorized to use such properties; and H.R. 2408, National Wildlife Refuge Volunteer Act of 2003. Testimony was heard from Marshall P. Jones, Jr. Deputy Director, U.S. Fish and Wildlife Service, Department of the Interior; and public witnesses.

NASA FLEXIBILITY ACT

Committee on Science: Subcommittee on Space and Aeronautics approved for full Committee action, as amended, H.R. 1085, NASA Flexibility Act of 2003.

COMPUTER RESERVATION SYSTEMS REGULATIONS AND SMALL BUSINESS—TRAVEL INDUSTRY

Committee on Small Business: Subcommittee on Regulatory Reform and Oversight held a hearing entitled: "CRS Regulations and Small Business in the Travel Industry" Testimony was heard from Tom Sullivan, Chief Counsel, Office of Advocacy, SBA; and public witnesses.

NATIONAL RAIL INFRASTRUCTURE FINANCING PROPOSALS

Committee on Transportation and Infrastructure: Subcommittee on Railroads held an oversight hearing on National Rail Infrastructure Financing Proposals. Testimony was heard from the following officials of the Department of Transportation: Allan Rutter, Administrator, Federal Railroad Administration; and Roger Nober, Chairman, Surface Transportation Board; Joseph Boardman, Commissioner, Department of Transportation, State of New York; and public witnesses.

VETERAN'S LEGISLATION

Committee on Veterans' Affairs: Ordered reported the following measures: H.R. 1516, as amended, National Cemetery Expansion Act of 2003; H.R. 2297, as amended, Veterans Benefits Act of 2003; H.R. 116, as amended, Veterans' New Fitzsimons Health Care Facilities Act of 2003; H.R. 1720, as amended, Veterans Health Care Facilities Capital Improvement Act; H.R. 2357, as amended, to amend title 38, United States Code, to establish standards of access to care for veterans seeking health care from the Department of Veterans Affairs; H.R. 2433, as amended, Health Care for Veterans of Project 112/Project SHAD Act of 2003; H.R. 2595, to restore the operation of the Native American Veteran Housing Loan Program during fiscal year 2003 to the scope of that program as in effect on September 30, 2002; and H. Con. Res. 159, declaring Emporia, Kansas, to be the founding city of the Veterans Day holiday and recognizing the contributions of Alvin J. King and Representative Ed Rees to the enactment into law of the observance of Veterans Day.

PROJECT BIOSHIELD ACT

Select Committee on Homeland Security: Ordered reported, as amended, H.R. 2122, Project BioShield Act of 2003.

NEW PUBLIC LAWS

(For last listing of Public Laws, see DAILY DIGEST, *p. D713)*

S. 342, to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act. Signed on June 25, 2003. (Public Law 108–36)

COMMITTEE MEETINGS FOR FRIDAY, JUNE 27, 2003

Senate

No meetings/hearings scheduled.

House

No committee meetings are scheduled.

Next Meeting of the **SENATE**

10:15 a.m., Friday, June 27

Senate Chamber

Program for Friday: Senate will be in a period of morning business.

Next Meeting of the **HOUSE OF REPRESENTATIVES**

2 p.m., Monday, July 7

House Chamber

Program for Monday: To be announced.

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